

# MARYLAND STATE DEPARTMENT OF HEALTH

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

Item #9 Film #G382 11/1/66 pc

## MEDICAL EXAMINER'S CERTIFICATE OF DEATH

14096

14098

FOR STATE HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. The pages 1 and 2 with the State Department of Health or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

1. PLACE OF DEATH a. COUNTY <b>Dorchester</b> MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <b>Florida</b> b. COUNTY	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Hurlock - Rural</b>		c. LENGTH OF STAY IN 1b <b>Winter Garden</b>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>Near Waddell's Corner</b>		d. STREET ADDRESS <b>729 East Bay Street</b>	
3. NAME OF DECEASED (Type or print) First <b>Cleo</b> Middle <b>Ballard</b> Last <b>Ballard</b>		4. DATE OF DEATH Month <b>October</b> Day <b>16</b> Year <b>1966</b>	
5. SEX <b>Male</b>	6. COLOR OR RACE <b>Negro</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>approx. 50</b> yrs.
9. AGE (In years last birthday) <b>approx. 50</b> yrs.		10. IF UNDER 1 YEAR Months <b>50</b> Days <b>50</b> Hours <b>50</b> Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Day Laborer</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Farm</b>	
11. BIRTHPLACE (State or foreign country) <b>USA</b>		12. CITIZEN OF WHAT COUNTRY? <b>USA</b>	
13. FATHER'S NAME		14. MOTHER'S MAIDEN NAME	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service)		16. SOCIAL SECURITY NO.	
17. INFORMANT		Address	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Heart pericardium and Heart thrombosis</b> 8234 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b>Local action of heart</b> DUE TO (c)			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)			
20a. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <b>car run off road</b>	
20c. TIME OF INJURY Month, Day, Year <b>11:00 a.m. 10-16-66</b>	20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input checked="" type="checkbox"/> at work	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <b>street</b>	20f. (City or town) (County) (State) <b>Winter Garden, FL</b>
21. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE <b>Edw Rieckert</b> M.D.		22. DATE SIGNED <b>10-16-66</b>	
EXAMINER'S NAME (Type) <b>Edw Rieckert E-New Market</b>		DEPUTY MEDICAL EXAMINER <input type="checkbox"/>	
23a. BURIAL OR CREMATION REMOVAL (Specify)	23b. DATE THEREOF <b>10-27-66</b>	23c. NAME OF CEMETERY OR CREMATORY <b>W. of Md. Med. School</b>	23d. LOCATION (City or Town) (County) (State) <b>BALTIMORE Md.</b>
24. FUNERAL DIRECTOR <b>J. J. Hampton and Son, Federalburg, Maryland</b>		25a. REC'D BY REGISTRAR <b>Charles Judge</b>	
25b. REGISTRAR'S SIGNATURE <b>Charles Judge</b>		DATE <b>OCT 28 1966</b>	

11002

11002

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND  
14087 CERTIFICATE OF DEATH 14099

1. PLACE OF DEATH a. COUNTY <b>Dorchester</b>		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Dorchester</b>	
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <b>Cambridge</b>		c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <b>Cambridge</b>	
c. LENGTH OF STAY IN 1b <b>50 years</b>		d. STREET ADDRESS <b>601 Maryland Avenue</b>	
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <b>Cambridge Maryland Hospital</b>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <b>JULIAN</b> Middle <b>B.</b> Last <b>BRINSFIELD</b>		4. DATE OF DEATH Month <b>October</b> Day <b>5</b> Year <b>1966</b>	
5. SEX <b>Male</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>Aug. 16, 1908</b>
9. AGE (In years last birthday) <b>58 yrs.</b>		10. IF UNDER 1 YEAR Months <b>5</b> Days <b>10</b> Hours <b>10</b> Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>None-Cripple</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>---</b>	
11. BIRTHPLACE (County & State, or foreign country) <b>Dorchester Co., Maryland</b>		12. CITIZEN OF WHAT COUNTRY? <b>USA</b>	
13. FATHER'S NAME <b>Julian B. Brinsfield</b>		14. MOTHER'S MAIDEN NAME <b>Mary Catherine Murphy</b>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <b>No</b>		16. SOCIAL SECURITY NO. <b>Unknown</b>	
17. INFORMANT <b>Mrs. Melvin Turner, Sr., Cambridge, Md.</b>		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Post-operative shock, peritonitis</b> <b>584X</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO (b) <b>Gall-stone ileus, liver abscess</b> DUE TO (c) <b>cholecystitis with lithiasis</b>		INTERVAL BETWEEN ONSET AND DEATH	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) <b>Rheumatoid arthritis, endocarditis</b>		19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of Item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. <b>19</b> p.m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from <b>OCT 4, 1966</b> , to <b>OCT 5, 1966</b> that (I) (we) last saw the deceased alive on <b>OCT 5, 1966</b> and that death occurred at <b>4AM</b> , from the causes and on the date stated above.			
22a. SIGNATURE <b>Lewis M. Burdette</b>		22b. DATE SIGNED <b>6 OCT 66</b>	
22c. PHYSICIAN'S NAME (Type) <b>Lewis M. Burdette</b>		22d. ADDRESS <b>601 Locust St. Cambridge, Md.</b>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		23b. DATE THEREOF <b>Oct 7, 1966</b>	
23c. NAME OF CEMETERY OR CREMATORY <b>Brookview Meth. Church</b>		23d. LOCATION (City, town or county) (State) <b>Brookview, Dor. Co., Md.</b>	
24. FUNERAL DIRECTOR <b>LeCompte Funeral Service, Cambridge, Maryland</b>		25a. REC'D BY REGISTRAR <b>Charles Judge</b>	
25b. REGISTRAR'S SIGNATURE <b>Charles Judge</b>		DATE <b>OCT 7, 1966</b>	

1900

1900

1900

1900

1900

1900

1900

1900

1900

1900

1900

1900

1900

1900

1900

1900

1900

1900

1900

1900

1900

1900

1900

1900

1900

1900

1900

1900

1900

1900

1900

1900

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and any event, within 72 hours after death.

VR A15 (4)  
20 M 1/66

MDARYLAND STATE DEPARTMENT OF HEALTH  
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

14098

CERTIFICATE OF DEATH

14100

1. PLACE OF DEATH a. COUNTY <b>Dorchester</b> MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Dorchester</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Cambridge</b>		c. LENGTH OF STAY IN 1b <b>Life</b>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>Cambridge Maryland Hospital</b>		d. STREET ADDRESS <b>706 Douglas Street</b>	
3. NAME OF DECEASED (Type or print) First <b>Gordy</b> Middle <b>Carr</b> Last <b>Carr</b>		4. DATE OF DEATH Month <b>October</b> Day <b>26</b> Year <b>19 66</b>	
5. SEX <b>Male</b>	6. COLOR OR RACE <b>Negro</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>May 25, 1910</b>
9. AGE (In years last birthday) <b>56</b> yrs.		10. IF UNDER 1 YEAR Months <b>6</b> Days <b>26</b> Hours <b>09</b> Min.	
11. BIRTHPLACE (County & State, or foreign country) <b>Dorchester Co., Md.</b>		12. CITIZEN OF WHAT COUNTRY? <b>USA</b>	
13. FATHER'S NAME <b>Joseph Carr</b>		14. MOTHER'S MAIDEN NAME <b>Martha Ennels</b>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <b>No</b>		16. SOCIAL SECURITY NO. <b>-----</b>	
17. INFORMANT <b>Issac Carr</b>		Address <b>Cambridge, Md.</b>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Bronchogenic Carcinoma</b> <b>1621</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) DUE TO (c) INTERVAL BETWEEN ONSET AND DEATH <b>6 months</b>			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. <b>19</b> p.m. <b>19</b>		20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> of work <input type="checkbox"/> of work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from <b>April</b> , 19 <b>66</b> , to <b>October 26</b> , 19 <b>66</b> that (I) (we) last saw the deceased alive on <b>Oct. 26</b> , 19 <b>66</b> , and that death occurred at <b>P.</b> M., from causes and on the date stated above.			
22a. SIGNATURE <b>J. Edwin Fassett</b>		22b. DATE SIGNED <b>10-29-66</b>	
22c. PHYSICIAN'S NAME (Type) <b>J. Edwin Fassett, M.D.</b>		22d. ADDRESS <b>727 Pine Street Cambridge, Md.</b>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		23b. DATE THEREOF <b>10/30/66</b>	
23c. NAME OF CEMETERY OR CREMATORY <b>Waugh</b>		23d. LOCATION (City or Town) (County) (State) <b>Cambridge Dor. Md.</b>	
24. FUNERAL DIRECTOR <b>Frederick C. Pollock</b>		25. REGISTRAR'S SIGNATURE <b>Charles Judge</b>	
25a. REC'D BY REGISTRAR <b>DATE NOV 3 1966</b>		25b. REGISTRAR'S SIGNATURE <b>Charles Judge</b>	

11111

11111

# MARYLAND STATE DEPARTMENT OF HEALTH

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

14099

## CERTIFICATE OF DEATH

14101

1. PLACE OF DEATH a. COUNTY <b>Dorchester</b> MARYLAND			2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Dorchester</b>		
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Cambridge</b>		c. LENGTH OF STAY In <b>Life</b>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Cambridge</b>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>521 W Pine Street</b>			d. STREET ADDRESS <b>521 Pine Street</b>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
3. NAME OF DECEASED (Type or print) First <b>Iona</b> Middle <b>Kiah</b> Last <b>Coleman</b>			4. DATE OF DEATH Month <b>Oct.</b> Day <b>10</b> Year <b>1966</b>		
5. SEX <b>Female</b>	6. COLOR OR RACE <b>Negro</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>Oct. 2, 1902</b>	9. AGE (In years last birthday) <b>64</b> yrs.	IF UNDER 1 YEAR Months Days Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Housewife</b>		10b. KIND OF BUSINESS OR INDUSTRY -----		11. BIRTHPLACE (County & State, or foreign country) <b>Dorchester Co., Md.</b>	
12. CITIZEN OF WHAT COUNTRY? <b>USA</b>			13. FATHER'S NAME <b>John W. Kiah</b>		
14. MOTHER'S MAIDEN NAME <b>Henrietta Clash</b>			15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <b>No</b>		
16. SOCIAL SECURITY NO. <b>214-28-3047</b>		17. INFORMANT <b>Lorraine Coleman</b> Address <b>Same</b>			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Coronary thrombosis</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) _____ (c) _____					INTERVAL BETWEEN ONSET AND DEATH
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)					19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <b>19</b>	20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work at work	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town)	(County)	(State)
21. I certify that (I) (this hospital) attended the deceased from <b>Oct. 8, 1966</b> , to <b>Oct. 10, 1966</b> , that (I) (we) last saw the deceased alive on <b>Oct. 10, 1966</b> , and that death occurred at <b>4 M.</b> from causes on and on the date stated above.					
22a. SIGNATURE <i>J. Edwin Fassett</i>		M.D. ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22b. DATE SIGNED <b>Oct. 13, 1966</b>	
22c. PHYSICIAN'S NAME (Type) <b>J. Edwin Fassett, M.D.</b>		22d. ADDRESS <b>727 Pine Street Cambridge, Md.</b>			
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>	23b. DATE THEREOF <b>10/15/66</b>	23c. NAME OF CEMETERY OR CREMATORY <b>Waugh</b>		23d. LOCATION (City or Town) (County) (State) <b>Cambridge Dor. Md.</b>	
24. FUNERAL DIRECTOR <i>Frederick C. [Signature]</i>		ADDRESS <b>Cambridge, Md.</b>		25a. REC'D BY REGISTRAR DATE <b>OCT 14 1966</b>	25b. REGISTRAR'S SIGNATURE <i>Charles Judge</i>

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and on any event, within 72 hours after death.

10141

1222

*[Faint, illegible handwritten text, possibly bleed-through from the reverse side of the page]*

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

CERTIFICATE OF DEATH

14100

14102

1. PLACE OF DEATH a. COUNTY <u>Worcester</u>		b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>Cambridge</u>		c. LENGTH OF STAY IN 1b		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Worcester</u>		c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>Cambridge, Md.</u>		d. STREET ADDRESS <u>601 CROSS ST.</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <u>John</u>		4. DATE OF DEATH Month <u>10</u> Day <u>24</u> Year <u>1966</u>		5. SEX <u>MALE</u>		6. COLOR OR RACE <u>NEGRO</u>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>3/1/1911</u>		9. AGE (in years last birthday) <u>55</u> yrs.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>TRUCKER</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>DRIVER</u>		11. BIRTHPLACE (County & State, or foreign country) <u>DORCHESTER</u>		12. CITIZEN OF WHAT COUNTRY? <u>YES</u>		13. FATHER'S NAME <u>JOHN CROMWELL</u>		14. MOTHER'S MAIDEN NAME <u>ANNIE WATERS</u>		15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>NO</u>	
16. SOCIAL SECURITY NO. <u>214-07-8088</u>		17. INFORMANT <u>Sister Cromwell, Cambridge, Md.</u>		18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Metastatic carcinoma</u> DUE TO (b) <u>Carunoma prostate</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (c) <u>177X</u>		INTERVAL BETWEEN ONSET AND DEATH <u>Four days</u>		PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)	
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)		20c. TIME OF INJURY Month, Day, Year Hour a.m. <u>19</u> p.m.		20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)		21. I certify that (I) (this hospital) attended the deceased from <u>10-20</u> , 1966 to <u>10-24</u> , 1966, that (I) (we) last saw the deceased alive on <u>Oct 24</u> , 1966, and that death occurred at <u>10</u> M, from the causes and on the date stated above.		22a. SIGNATURE <u>J. Edwin Fassett</u>	
22c. PHYSICIAN'S NAME (Type) <u>J. Edwin Fassett M.D.</u>		22d. ADDRESS <u>727 Pine St. Cambridge, Maryland</u>		22b. DATE SIGNED <u>Oct. 27, 1966</u>		23a. BURIAL OR CREMATION (Specify) <u>Buried</u>		23b. DATE THEREOF <u>10/29/66</u>		23c. NAME OF CEMETERY OR CREMATORY <u>Bel Bel Cem.</u>		23d. LOCATION (City, town or county) (State) <u>Cambridge, Md.</u>	
24. FUNERAL DIRECTOR'S SIGNATURE <u>Brooks M West</u>		25a. REC'D BY REGISTRAR <u>NOV 4 1966</u>		25b. REGISTRAR'S SIGNATURE <u>Charles Judge</u>		25c. ADDRESS <u>Cambridge, Md.</u>		25d. DATE		25e. SIGNATURE		25f. ADDRESS	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

2444

907 延康

125 01

93526-93531

22.

MARYLAND STATE DEPARTMENT OF HEALTH

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

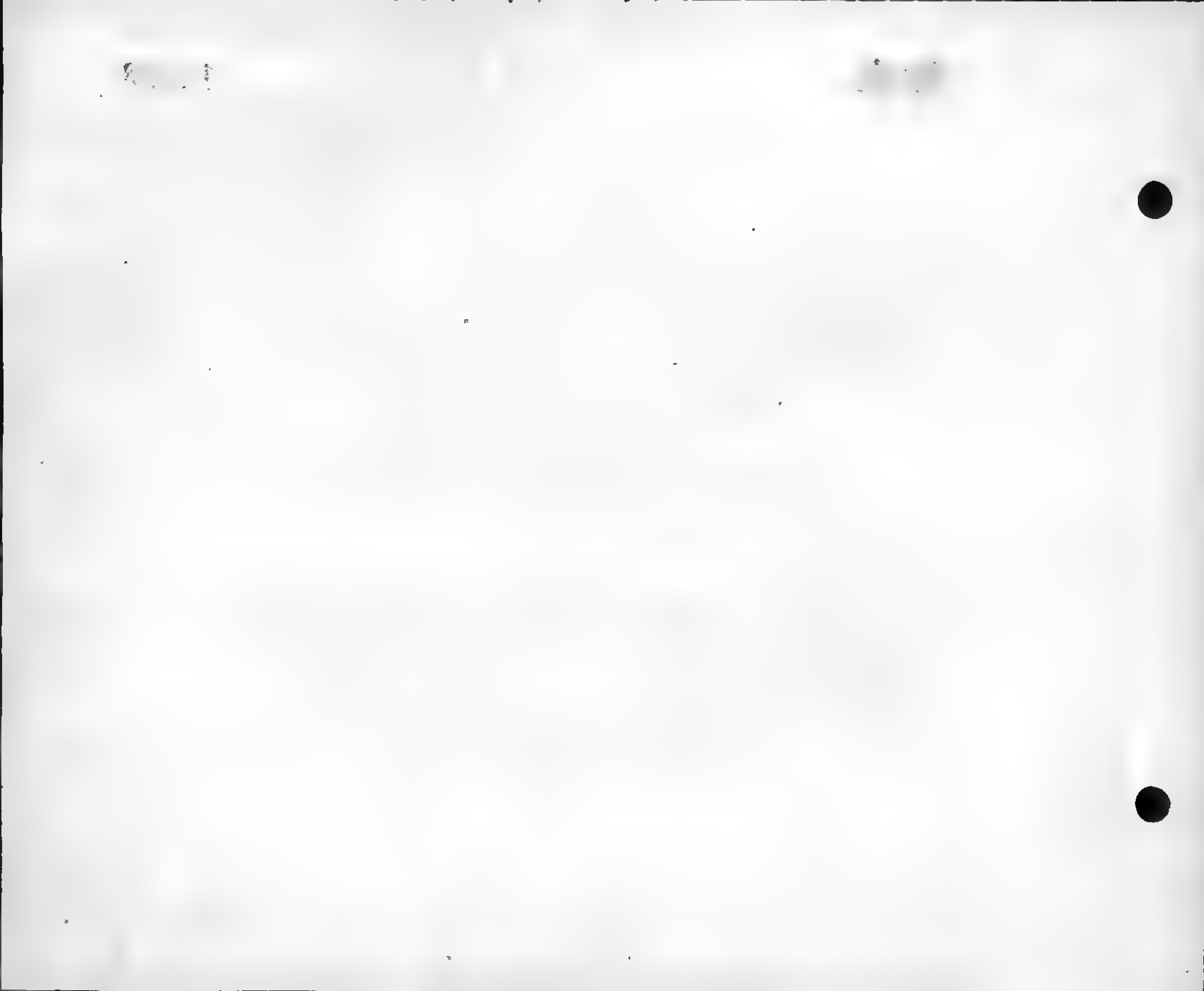
CERTIFICATE OF DEATH

14103

1. PLACE OF DEATH a. COUNTY <b>Dorchester</b> MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Dorchester</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Cambridge</b>		c. LENGTH OF STAY IN 1b <b>Life</b>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>Cambridge Maryland Hospital</b>		d. STREET ADDRESS <b>Rural- Church Creek</b>	
3. NAME OF DECEASED (Type or print) First <b>Goldie</b> Middle <b>Rufus</b> Last <b>Dean</b>		4. DATE OF DEATH Month <b>Oct.</b> Day <b>13</b> Year <b>19 66</b>	
5. SEX <b>Male</b>	6. COLOR OR RACE <b>Negro</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>Nov. 10, 1899</b>
9. AGE (In years lost birthday) <b>66 yrs</b>		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Laborer</b>	
11. BIRTHPLACE (County & State or foreign country) <b>Dorchester Co., Md.</b>		12. CITIZEN OF WHAT COUNTRY? <b>USA</b>	
13. FATHER'S NAME <b>Richard Dean</b>		14. MOTHER'S MAIDEN NAME <b>Sarah Harris</b>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (If yes give year or dates of service) <b>Yes WW I</b>		16. SOCIAL SECURITY NO. <b>213-07-6580</b>	
17. INFORMANT <b>A Vermont Dean</b>		Address <b>Church Creek, Md.</b>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Coronary thrombosis</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) _____ (c) _____			INTERVAL BETWEEN ONSET AND DEATH <b>One day</b>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b>Bleeding duodenal ulcer</b>			19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. _____ p.m. <b>19</b>	20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work at work	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that (I) (this hospital) attended the deceased from <b>10-12-</b> , 19 <b>66</b> , to <b>10-13-</b> , 19 <b>66</b> that (I) (we) last saw the deceased alive on <b>10-13-</b> , 19 <b>66</b> and that death occurred at _____ M, from causes and on the date stated above.			
22a. SIGNATURE <i>J. Edwin Fassett</i>		22b. DATE SIGNED <b>Oct. 17, 1966</b>	
22c. PHYSICIAN'S NAME (Type) <b>J. Edwin Fassett, M.D.</b>		22d. ADDRESS <b>727 Pine Street Cambridge, Md.</b>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>	23b. DATE THEREOF <b>10/16/66</b>	23c. NAME OF CEMETERY OR CREMATORY <b>Linas Road</b>	23d. LOCATION (City or Town) (County) (State) <b>Dorchester Co., Md.</b>
24. FUNERAL DIRECTOR <i>Frederick C. DeLoach</i>		25a. REC'D BY REGISTRAR <b>DATE OCT 20 1966</b>	
		25b. REGISTRAR'S SIGNATURE <i>Charles Judge</i>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND  
**CERTIFICATE OF DEATH**

14102

15574

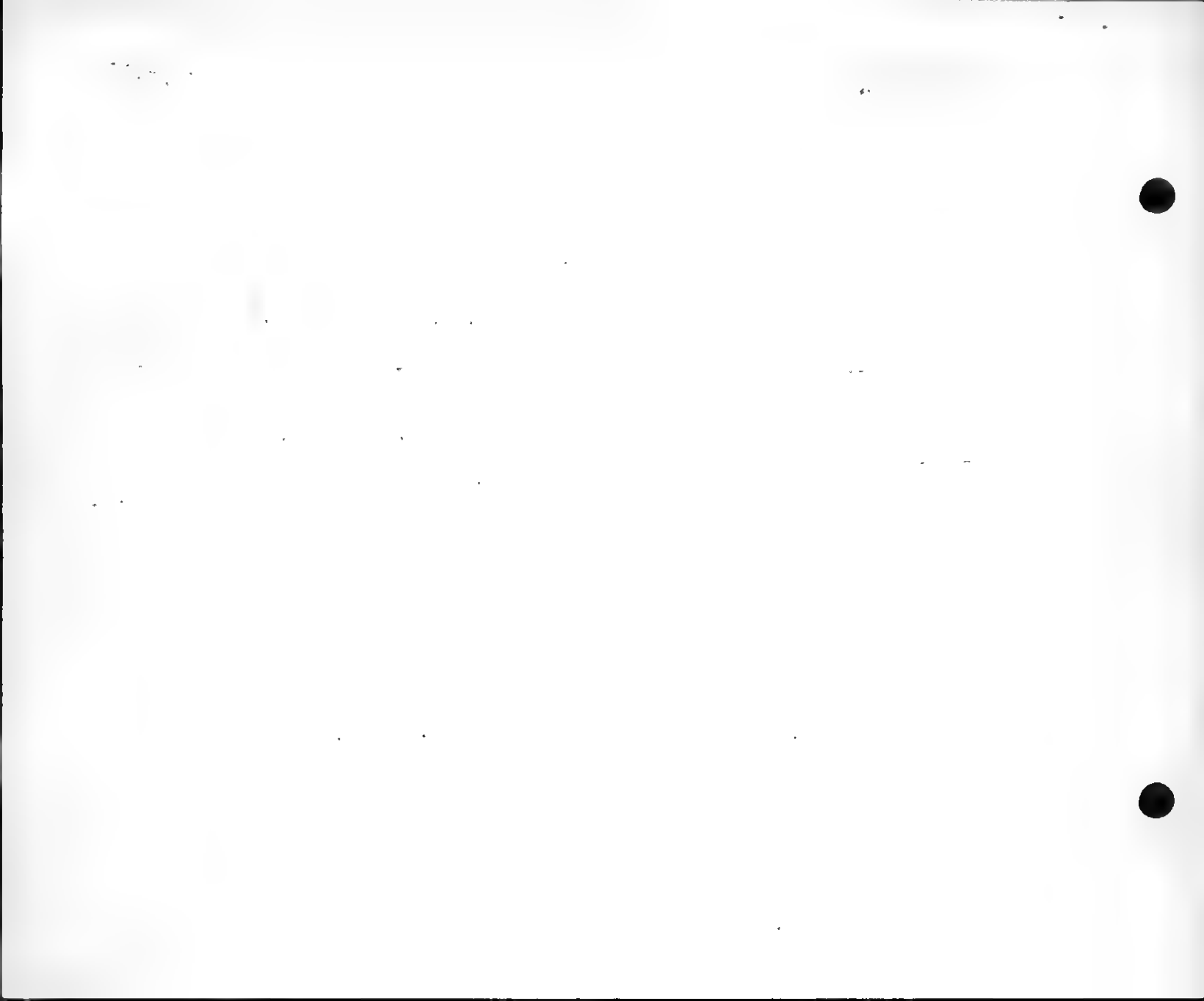
1. PLACE OF DEATH a. COUNTY <b>Dorchester</b> b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <b>Cambridge</b> c. LENGTH OF STAY IN 1b <b>Unk.</b> d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <b>Cambridge Maryland Hospital</b>				2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Dorchester</b> c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <b>Cambridge</b> d. STREET ADDRESS <b>Pine Street</b>			
3. NAME OF DECEASED (Type or print) <b>Ashton</b>		First Middle Last <b>Dennis</b>		4. DATE OF DEATH Month <b>Oct.</b> Day <b>29</b> Year <b>1966</b>			
5. SEX <b>Male</b>	6. COLOR OR RACE <b>Negro</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>May 3, 1910</b>	9. AGE (In years last birthday) <b>56</b> yrs.	IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.		
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Laborer</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>-----</b>		11. BIRTHPLACE (County & State, or foreign country) <b>Accomac Co., Vir.</b>			
12. CITIZEN OF WHAT COUNTRY? <b>USA</b>		13. FATHER'S NAME <b>James Dennis</b>					
14. MOTHER'S MAIDEN NAME <b>Anna Mae Dennis</b>		15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <b>No</b> (If yes give war or dates of service) <b>-----</b>					
16. SOCIAL SECURITY NO. <b>-----</b>		17. INFIRMANT <b>Minnie Dennis</b> Address <b>Cambridge, Md.</b>					
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Lobar Pneumonia</b> <b>490X</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of Item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <b>19</b>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)			
20f. (City or town) (County) (State)		21. I certify that (I) (this hospital) attended the deceased from <b>10/15/</b> , 19 <b>66</b> , to <b>10/29/</b> , 19 <b>66</b> , that (I) (we) last saw the deceased alive on <b>Oct. 29,</b> 19 <b>66</b> , and that death occurred at <b>-----</b> M, from the causes and on the date stated above.					
22a. SIGNATURE <b>J. Edwin Fassett</b>		M.D. ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22b. DATE SIGNED <b>10/4/66</b>			
22c. PHYSICIAN'S NAME (Type) <b>J. Edwin Fassett, M.D.</b>		22d. ADDRESS <b>727 Pine Street Cambridge, Md.</b>					
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		23b. DATE THEREOF <b>11/5/66</b>		23c. NAME OF CEMETERY OR CREMATORY <b>Bethel</b>			
23d. LOCATION (City, town or county) (State) <b>Cambridge Dor. Md.</b>		24. FUNERAL DIRECTOR <b>Frederick C. Davis</b> ADDRESS <b>Cambridge, Md.</b>					
25a. REC'D BY REGISTRAR <b>NOV 14 1966</b>		25b. REGISTRAR'S SIGNATURE <b>Charles Judge</b>					



FOR STATE  
HEALTH DEPT

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If only delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.  
TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

14103 MEDICAL EXAMINER'S CERTIFICATE OF DEATH 14104									
1 PLACE OF DEATH a. COUNTY <u>Dorchester</u> MARYLAND					2 USUAL RESIDENCE (Where deceased lived if institut on Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Wicomico</u>				
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Cambridge</u>			c. LENGTH OF STAY in 1b <u>2 yr.</u>		c. CITY OR TOWN (If out of corporate limits, write RURAL and give nearest town) <u>Delmar (rural)</u>				
3 NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Eastern Shore State Hosp.</u>					d. STREET ADDRESS <u>R. D #1</u>			e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3 NAME OF DECEASED (Type or print) <u>Rosie</u>		First <u>ELLEN</u>		Middle <u>Hall</u>		Last		4 DATE OF DEATH Month <u>10</u> Day <u>16</u> Year <u>1966</u>	
5 SEX <u>F</u>		6 COLOR OR RACE <u>W</u>		7 MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8 DATE OF BIRTH <u>Nov. 24, 1889</u>		9 AGE (In years last birthday) <u>76</u> yrs	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Unknown (None)</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>-</u>		11 BIRTHPLACE (State or foreign country) <u>Unknown Maryland</u>			12 CITIZEN OF WHAT COUNTRY? <u>Unknown USA</u>		
13 FATHER'S NAME <u>Charles</u>					14 MOTHER'S M A DEN NAME <u>unknown</u>				
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <u>unknown</u>					16. SOCIAL SECURITY NO <u>unknown</u>				
17. INFORMANT <u>Christina May Townsend Thomas (Grand daughter)</u>					Address <u>Eastern Shore State Hosp. 11113, State</u>				
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <u>Immune Pneumonia</u> 9047 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last (b) <u>Influenza</u> DUE TO (c)					19. INTERVAL BETWEEN ONSET AND DEATH <u>1 week</u>				
PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)					19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>				
20a. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> OR CONTRIBUTING CAUSE OF DEATH					20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part I of item 18) <u>Fall in hospital</u>				
20c. TIME OF INJURY Month, Day, Year Hour a.m. <u>7</u> p.m. <u>10/13/1966</u>			20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input checked="" type="checkbox"/> at work at work		20e. PLACE OF INJURY (Home, farm, factory, street, office, etc.) <u>Hospital</u>		20f. (City or town) (County) (State) <u>Cambridge Wicomico Md</u>		
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> . Inspection <input type="checkbox"/> . Inquiry <input type="checkbox"/> . and in my opinion death resulted from Natural causes <input type="checkbox"/> . Accident <input checked="" type="checkbox"/> . Suicide <input type="checkbox"/> . Homicide <input type="checkbox"/> . Undetermined manner <input type="checkbox"/>									
ACTUAL SIGNATURE <u>John Mace Jr.</u> M.D.					22. DATE SIGNED <u>10/15/66</u>				
EXAMINER'S NAME (Type) <u>JOHN MACE JR.</u>					CHIEF MED. CA. EXAMINER <input type="checkbox"/> ASS STANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MED. CA. EXAMINER <input checked="" type="checkbox"/> Address (Street, city, town, or county)				
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		23b. DATE THEREOF <u>Oct. 20, 1966</u>		23c. NAME OF CEMETERY OR CREMATORY <u>Line Church Cemetery</u>			23d. LOCATION (City or town) (County) (State) <u>Wicomico County, Maryland</u>		
24. FUNERAL DIRECTOR <u>HOLLOWAY &amp; CO. PANY, SALISBURY, MARYLAND</u>					25a. REC'D BY REGISTRAR DATE <u>OCT 24 1966</u>		25b. REGISTRAR'S SIGNATURE <u>Charles Judge</u>		



## MARYLAND STATE DEPARTMENT OF HEALTH

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

## CERTIFICATE OF DEATH

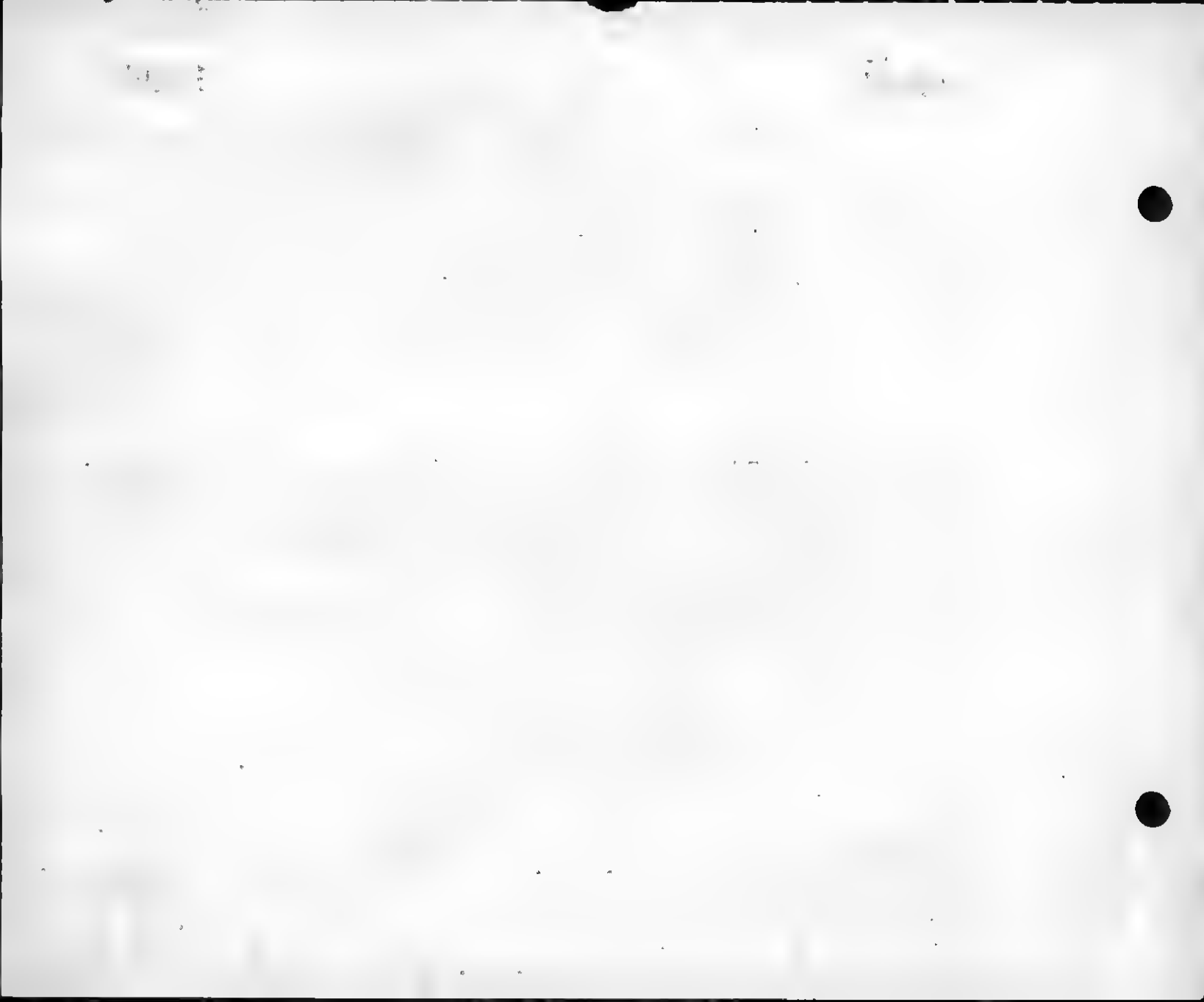
11104

14105

1. PLACE OF DEATH a. COUNTY <b>Dorchester</b> MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Dorchester</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Cambridge</b>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Cambridge</b>	
c. LENGTH OF STAY in 1b <b>1 year</b>			
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>Cambridge Maryland Hospital</b>		d. STREET ADDRESS <b>858 Park Lane</b>	
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First Middle Last <b>Rosie Daniel Horton</b>		4. DATE OF DEATH Month Day Year <b>Oct. 7 1966</b>	
5. SEX <b>Female</b>	6. COLOR OR RACE <b>Negro</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>June 30, 1894</b>
9. AGE (In years last birthday) <b>72</b> yrs.		10. IF UNDER 1 YEAR Months Days IF UNDER 24 HRS. Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Laborer</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>-----</b>	
11. BIRTHPLACE (County & State, or foreign country) <b>North Carolina</b>		12. CITIZEN OF WHAT COUNTRY? <b>USA</b>	
13. FATHER'S NAME <b>Clif Horton</b>		14. MOTHER'S MAIDEN NAME <b>Unknown</b>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <b>No</b>		16. SOCIAL SECURITY NO. <b>None</b>	
17. INFORMANT <b>Lula Spicer</b>		Address <b>Cambridge, Md.</b>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Cardiac decompensation</b> <b>4200</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last } (b) <b>Arteriosclerotic heart disease</b> DUE TO (c)			INTERVAL BETWEEN ONSET AND DEATH
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <b>19</b>	20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work at work	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg, etc.)	20f. (City or town) (County) (State)
21. I certify that (I) (this hospital) attended the deceased from <b>Sept. 25, 1966</b> , to <b>Oct. 7, 1966</b> , that (I) (we) last saw the deceased alive on <b>Oct. 7, 1966</b> , and that death occurred at <b>Oct. 7, 1966</b> , M, from causes on the date stated above.			
22a. SIGNATURE <b>J. Edwin Fassett</b>		22b. DATE SIGNED <b>Oct. 7, 1966</b>	
22c. PHYSICIAN'S NAME (Type) <b>J. Edwin Fassett, M.D.</b>		22d. ADDRESS <b>727 Pine Street Cambridge, Md.</b>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Re-Burial</b>	23b. DATE THEREOF <b>10/13/66</b>	23c. NAME OF CEMETERY OR CREMATORY <b>Bells Fork</b>	23d. LOCATION (City or Town) (County) (State) <b>Greenville, N. Carolina</b>
24. FUNERAL DIRECTOR <b>Frederick C. DeLois</b>		25a. REC'D BY REGISTRAR <b>Charles Judge</b>	
ADDRESS <b>Cambridge, Md.</b>		DATE <b>OCT 14 1966</b>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. The funeral director should remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

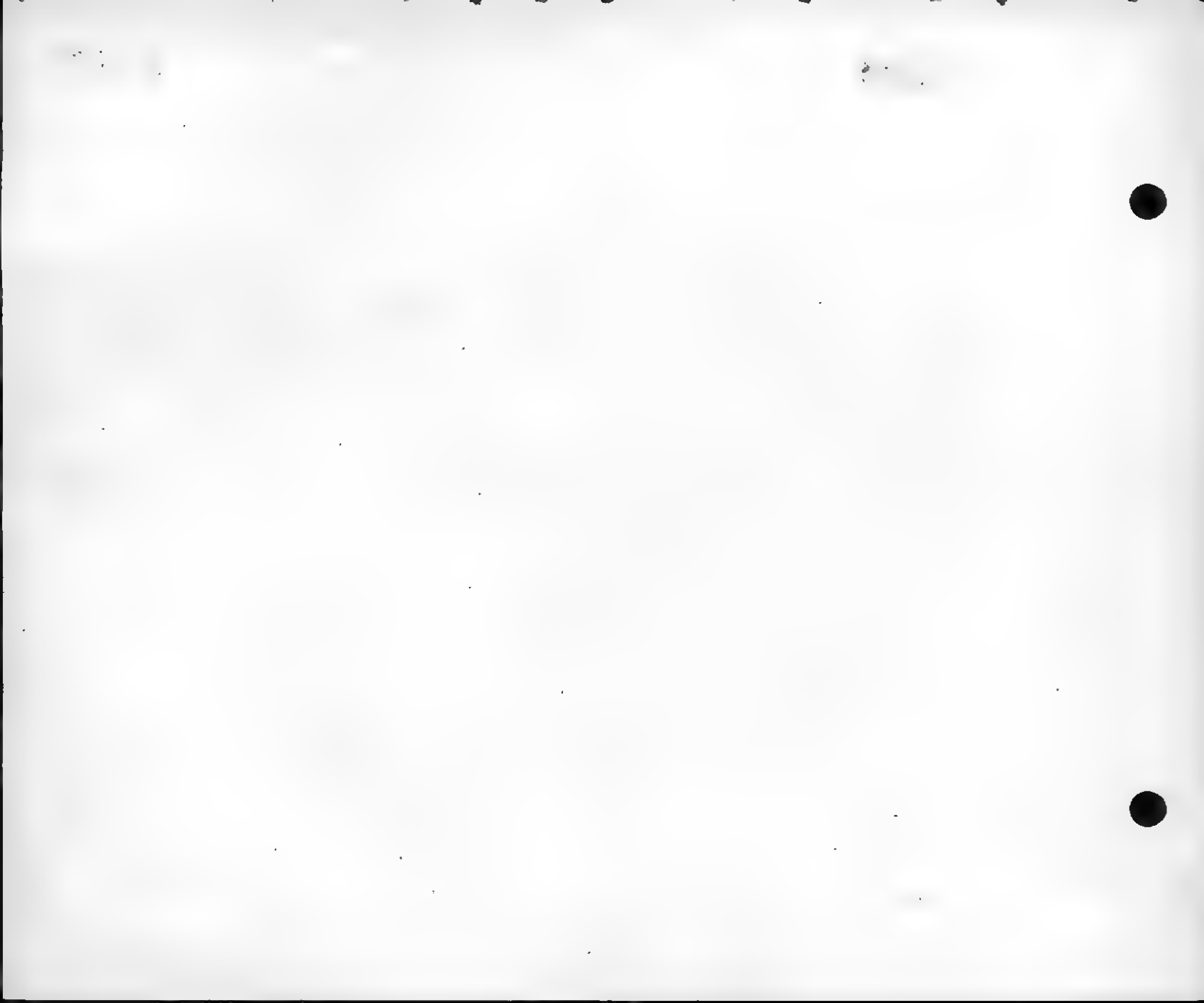
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

CERTIFICATE OF DEATH

1. PLACE OF DEATH a. COUNTY <b>DORCHESTER</b>		b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>CAMBRIDGE</b>		c. LENGTH OF STAY IN 1b <b>89 years</b>		2. USUAL RESIDENCE (Where deceased lived, if Institution: Residence before admission) a. STATE <b>MARYLAND</b> b. COUNTY <b>DORCHESTER</b>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>CAMBRIDGE</b>		d. STREET ADDRESS <b>311 GLENBURN</b>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) <b>OTWAY</b>		First <b>F.</b>		Middle <b>HUBBERT</b>		Last <b>HUBBERT</b>		4. DATE OF DEATH Month <b>10</b> Day <b>27</b> Year <b>1966</b>							
5. SEX <b>MALE</b>		6. COLOR OR RACE <b>WHITE</b>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <b>1877</b> <b>3-12-87</b>		9. AGE (In years last birthday) <b>89 yrs.</b>		IF UNDER 1 YEAR Months <b>8</b> Days <b>9</b> Hours <b>15</b> Min. <b>00</b>		IF UNDER 24 HRS. Hours <b>15</b> Min. <b>00</b>			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>STORE OWNER</b>				10b. KIND OF BUSINESS OR INDUSTRY <b>FEED STORE</b>				11. BIRTHPLACE (County & State, or foreign country) <b>DORCHESTER, MD.</b>				12. CITIZEN OF WHAT COUNTRY? <b>U.S.</b>			
13. FATHER'S NAME <b>TILMAN C. HUBBERT</b>						14. MOTHER'S MAIDEN NAME <b>AMANDA SIRMAN</b>									
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <b>UNKNOWN</b>				16. SOCIAL SECURITY NO. <b>217-30-8529</b>				17. INFORMANT <b>SHIRLEY SMITH</b>				Address <b>311 Glenburn Ave.</b>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>GENERALIZED DEBILITY</b> <b>534A</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b>Senility</b> (c) <b>Cerebral atherosclerosis</b>												INTERVAL BETWEEN ONSET AND DEATH <b>7 days</b>			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)															
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)											
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <b>19</b>				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>				20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)				20f. (City or town) (County) (State)			
21. I certify that (I) (this hospital) attended the deceased from <b>9-26</b> , 1966, to <b>10-27</b> , 1966, that (I) (we) last saw the deceased alive on <b>10-24</b> , 1966, and that death occurred at <b>11 AM</b> , from the causes and on the date stated above.															
22a. SIGNATURE <b>Richard G. Bilodeau</b>								M.D. ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22b. DATE SIGNED <b>10-27-66</b>					
22c. PHYSICIAN'S NAME (Type) <b>RICHARD G. BILODEAU</b>								22d. ADDRESS <b>116 OAKLEY ST. CAMBRIDGE, MD.</b>							
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>				23b. DATE THEREOF <b>Oct 29 1966</b>		23c. NAME OF CEMETERY OR CREMATORY <b>Dorchester Memorial Park</b>				23d. LOCATION (City, town or county) (State) <b>Cambridge, Maryland</b>					
24. FUNERAL DIRECTOR <b>LeCompte Funeral Service, Cambridge, Maryland</b>								ADDRESS		25a. REC'D BY REGISTRAR DATE <b>OCT 31 1966</b>		25b. REGISTRAR'S SIGNATURE <b>J. Charles Judge</b>			

10/27/66



# MARYLAND STATE DEPARTMENT OF HEALTH

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

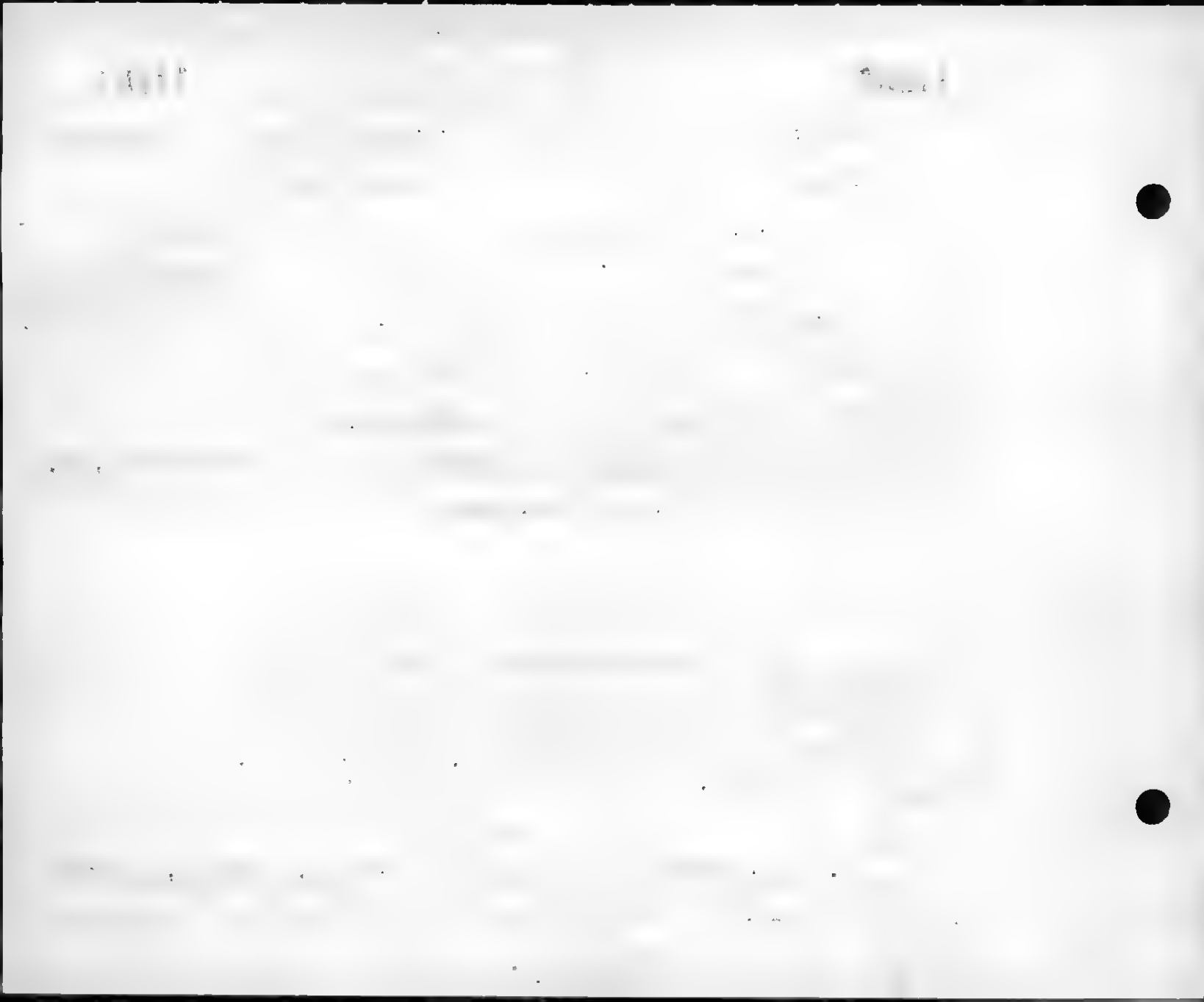
## CERTIFICATE OF DEATH

14107

1. PLACE OF DEATH a. COUNTY <b>Dorchester</b> MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Dorchester</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Cambridge</b>		c. LENGTH OF STAY IN 1b <b>Fishing Creek</b>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>Cambridge Maryland Hospital Inc</b>		d. STREET ADDRESS <b>Fishing Creek</b>	
3. NAME OF DECEASED (Type or print) <b>WILLIAM</b> First <b>W.</b> Middle <b>Jr</b> Last <b>Insley</b>		4. DATE OF DEATH <b>October 5</b> 19 <b>66</b>	
5. SEX <b>male</b>	6. COLOR OR RACE <b>white</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>October 4, 1966</b>
9. AGE (In years last birthday) yrs <b>1</b> Months <b>13</b> Days <b>35</b>		10. BIRTHPLACE (County & State, or foreign country) <b>Maryland</b>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>none</b>		11. CITIZEN OF WHAT COUNTRY? <b>U S A</b>	
13. FATHER'S NAME <b>William Wesley Insley</b>		14. MOTHER'S MAIDEN NAME <b>Barbara Ann Dean</b>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <b>no</b>		16. SOCIAL SECURITY NO. <b>none</b>	
17. INFORMANT <b>mother</b>		Address <b>Fishing Creek, Md.</b>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Hyaline Memb. Disease</b> <b>7730</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last, (b) (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			INTERVAL BETWEEN ONSET AND DEATH
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)
20c. TIME OF INJURY Month, Day, Year Hour a.m. <b>19</b> p.m.	20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that (I) (this hospital) attended the deceased from <b>Oct. 4</b> , 19 <b>66</b> , to <b>Oct. 5</b> , 19 <b>66</b> , that (I) (we) last saw the deceased alive on <b>Oct. 5</b> , 19 <b>66</b> , and that death occurred at <b>1:30 PM</b> , from causes and on the date stated above.			
22a. SIGNATURE <b>Dr. Wilbur Baumann</b>		22b. DATE SIGNED <b>10-5-66</b>	
22c. PHYSICIAN'S NAME (Type) <b>Dr. Wilbur Baumann</b>		22d. ADDRESS <b>603 Church St. Cambridge, Maryland</b>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>	23b. DATE THEREOF <b>10-8-66</b>	23c. NAME OF CEMETERY OR CREMATORY <b>Dorchester Memorial Park</b>	23d. LOCATION (City or Town) (County) (State) <b>Cambridge Dorchester Md</b>
24. FUNERAL DIRECTOR <b>Lecompte Funeral Service</b>		25a. REC'D BY REGISTRAR <b>Charles Judge</b>	
ADDRESS <b>308 High St. Cambridge, Md</b>		25b. REGISTRAR'S SIGNATURE <b>Charles Judge</b>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.



TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death if any delay is necessary, please execute the certificate, writing the word "pending" in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 3 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health at its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

B.P.

VA 15ME (5)  
6M 1/66

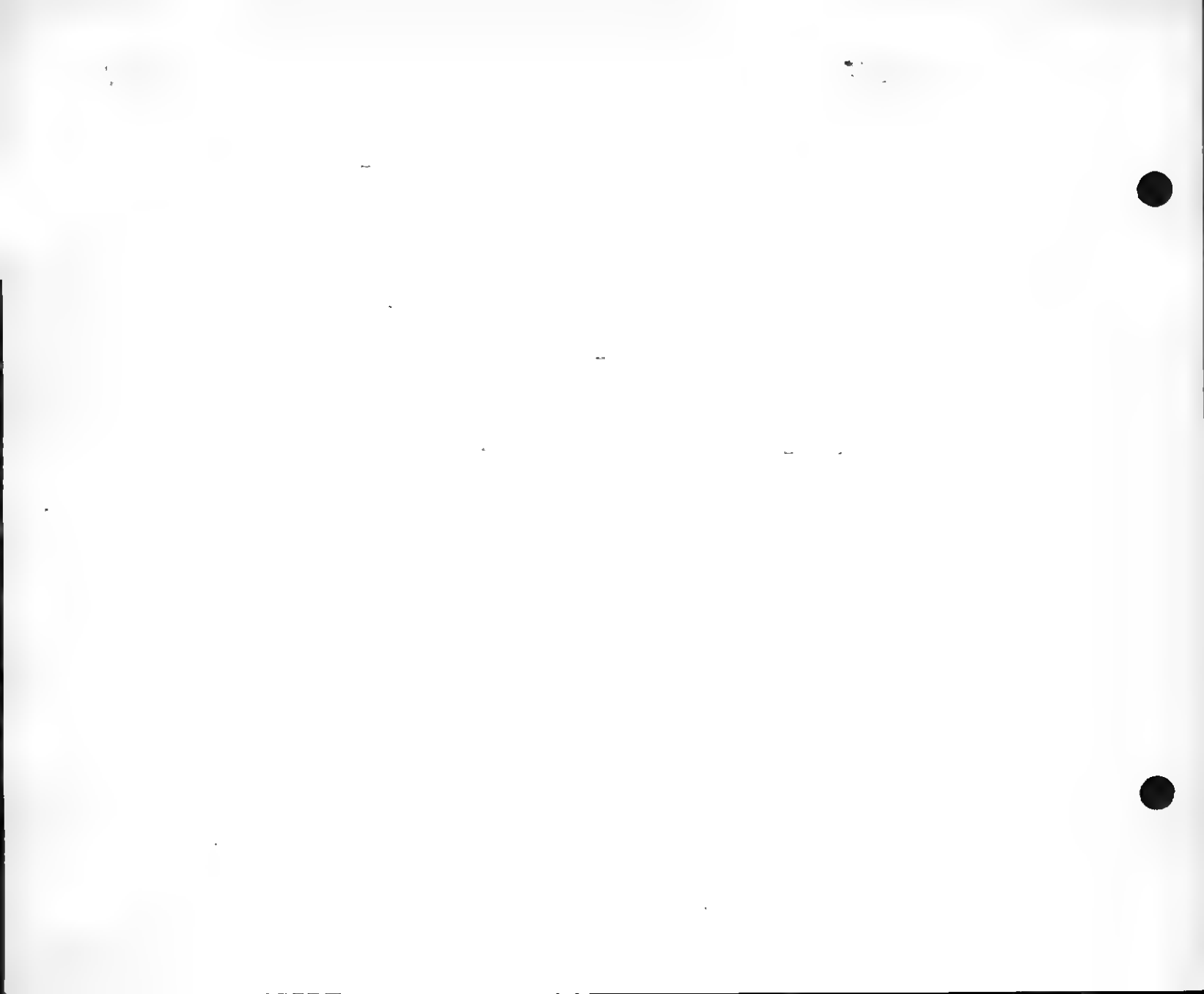
MARYLAND STATE DEPARTMENT OF HEALTH  
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

14107

14108

1. PLACE OF DEATH a COUNTY <b>Dorchester</b> MARYLAND		2 USUAL RESIDENCE (Where deceased lived, if institution, Residence before admission) a STATE <b>Maryland</b> b COUNTY <b>Dorchester</b>	
b CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Cambridge</b>		c LENGTH OF STAY IN 1b <b>1 day</b>	
d NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>Cambridge Maryland Hospital</b>		e IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3 NAME OF DECEASED (Type or print) First <b>LILLIAN</b> Middle <b>PRITCHETT</b> Last <b>JONES</b>		4 DATE OF DEATH Month <b>Oct.</b> Day <b>24</b> Year <b>1966</b>	
5 SEX <b>Female</b>	6 COLOR OR RACE <b>White</b>	7 MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8 DATE OF BIRTH <b>Feb. 11, 1882</b>
9 AGE (in years, last birthday) <b>84</b>		10 UNDER 1 YEAR Months <b>5</b> Days <b>19</b> Hours <b>19</b> Min <b>66</b>	
10a USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Teacher-Housewife</b>		10b KIND OF BUSINESS OR INDUSTRY <b>School-Home</b>	
11 BIRTHPLACE (State or foreign country) <b>Dorchester Co., Md.</b>		12 CITIZEN OF WHAT COUNTRY? <b>USA</b>	
13 FATHER'S NAME <b>John T. Pritchett</b>		14 MOTHER'S MAIDEN NAME <b>Arietta Langrall</b>	
15 WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or Unknown) (If yes, give war or dates of service) <b>No</b>		16 SOCIAL SECURITY NO <b>Unknown</b>	
17 INFORMANT <b>Mrs. Carroll Todd, Toddville, Md.</b>		Address	
18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <b>Coronary occlusion</b> <b>721</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost } (b) _____ (c) _____		INTERVAL BETWEEN ONSET AND DEATH <b>5 Mins.</b>	
PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19 WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH		20b DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18)	
20c TIME OF INJURY Month, Day, Year Hour a.m. _____ p.m. <b>19</b>		20d INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	
20e PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f (City or town) (County) (State)	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input type="checkbox"/> , and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE <b>John Mace Jr. M.D.</b>		22. DATE SIGNED <b>10/24/66</b>	
EXAMINER'S NAME (Type) <b>John Mace Jr. M.D.</b>		Address (Street, city, town, or county) <b>Cambridge, Md.</b>	
23a BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>	23b DATE THEREOF <b>Oct 26 1966</b>	23c NAME OF CEMETERY OR CREMATORY <b>Dorchester Memorial Park</b>	23d LOCATION (City or town) (County) (State) <b>Cambridge, Maryland</b>
24. FUNERAL DIRECTOR <b>LeCompte Funeral Service, Cambridge, Maryland</b>		25a REC'D BY REGISTRAR DATE <b>OCT 26 1966</b>	
ADDRESS		25b REGISTRAR'S SIGNATURE <b>Charles Judge</b>	



MARYLAND STATE DEPARTMENT OF HEALTH

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

14108

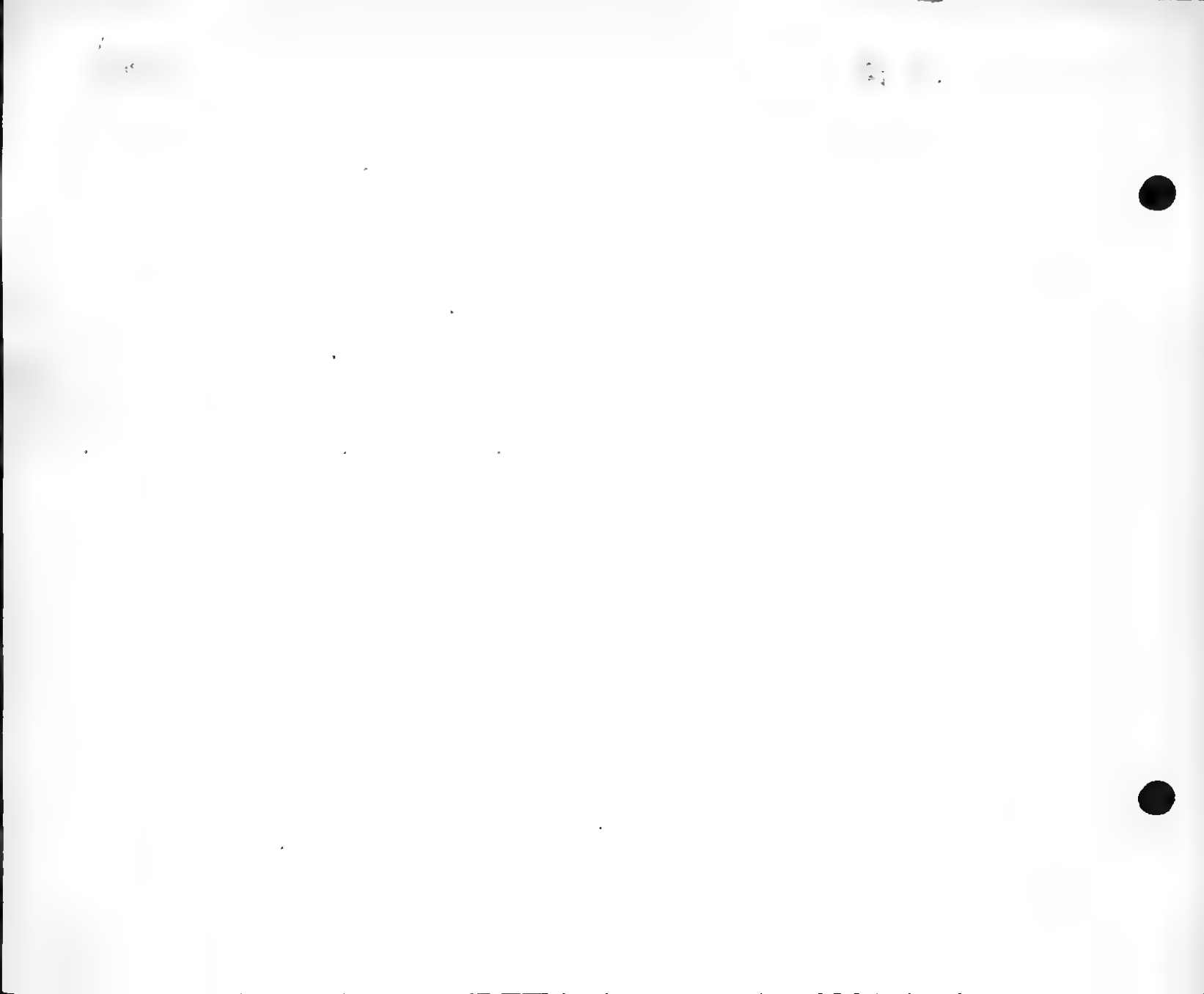
14109

FOR STATE  
HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

1. PLACE OF DEATH a. COUNTY <b>Dorchester</b> MARYLAND				2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <b>Dorchester</b> b. COUNTY <b>Maryland</b>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Rural-Cambridge</b>				c. LENGTH OF STAY IN TB <b>Life</b>			
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>RFD #3, Morris Neck Road</b>				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First <b>BANNIE</b> Middle <b>MILLS</b> Last <b>MILLS</b>				4. DATE OF DEATH Month <b>October</b> Day <b>1</b> Year <b>66</b>			
5. SEX <b>Male</b>		6. CO. OR OR RACE <b>White</b>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <b>Nov. 20, 1896</b>	
9. AGE (In years last birthday) <b>69</b> yrs		10. F UNDER 1 YEAR Months <input type="checkbox"/> Days <input type="checkbox"/> Hours <input type="checkbox"/> Min <input type="checkbox"/>		11. BIRTHPLACE (State or foreign country) <b>Dorchester Co., Maryland</b>		12. CITIZEN OF WHAT COUNTRY? <b>USA</b>	
10a. USUAL OCCUPATION (Give kind of work done during most of work life, even if retired) <b>Waterman</b>				10b. KIND OF BUSINESS OR INDUSTRY <b>Seafood</b>			
13. FATHER'S NAME <b>Ben Mills</b>				14. MOTHER'S MAIDEN NAME <b>Louise Bromwell</b>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <b>Yes WW 1</b>		16. SOCIAL SECURITY NO <b>Unknown</b>		17. INFORMANT <b>Mr. Galen Mills, RFD 3, Cambridge, Md.</b>			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Coronary occlusion</b> DUE TO (b) _____ Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (c) _____ DUE TO (c) _____						INTERVAL BETWEEN ONSET AND DEATH <b>Instant</b>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)						19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18)					
20c. TIME OF INJURY Month, Day, Year Hour a.m. _____ p.m. <b>19</b>		20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work at work		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input type="checkbox"/> , and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/>							
ACTUAL SIGNATURE <i>John Mace Jr.</i> EXAMINER'S NAME (Type) <b>John Mace Jr. M.D.</b>				22. DATE SIGNED <b>10/3/66</b> Cambridge, Md.			
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		23b. DATE THEREOF <b>Oct 4, 1966</b>		23c. NAME OF CEMETERY OR CREMATORY <b>Dorchester Memorial Park</b>		23d. LOCATION (City or Town) (County) (State) <b>Cambridge, Maryland</b>	
24. FUNERAL DIRECTOR <b>LeCompte Funeral Service, Cambridge, Maryland</b>				25a. REC'D BY REG STRAR <b>OCT 4 1966</b>		25b. REGISTRAR'S SIGNATURE <i>Charles Judge</i>	



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then, please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

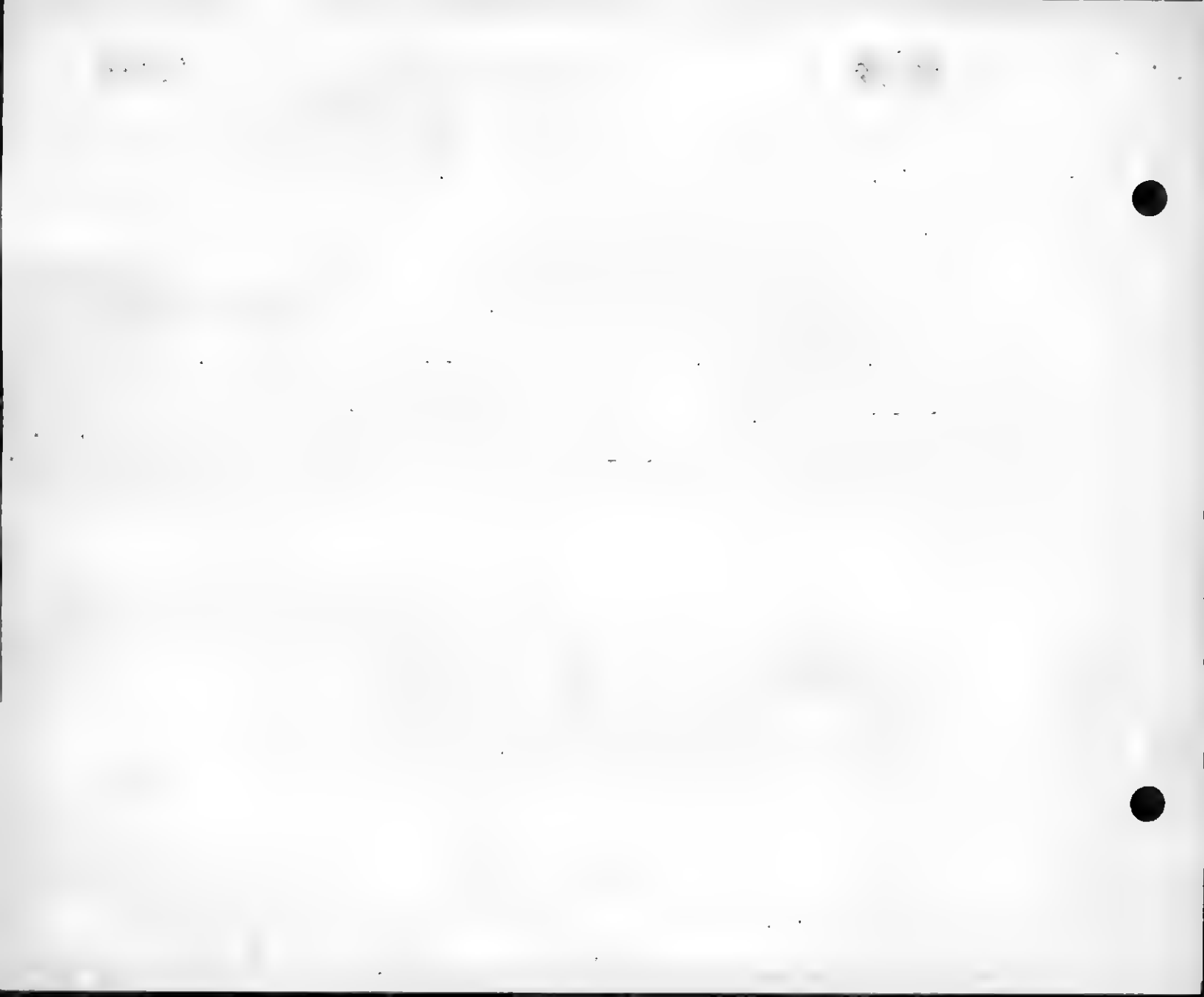
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

# CERTIFICATE OF DEATH

13109

14110

1. PLACE OF DEATH a. COUNTY <u>Dorchester</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if instit. on. Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Wicomico</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Cambridge</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Salisbury</u>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Eastern Shore State Hosp.</u>		d. STREET ADDRESS <u>615 Baker St.</u>	
3. NAME OF DECEASED (Type or print) First Middle Last <u>Carrie BELL Purcell</u>		4. DATE OF DEATH Month Day Year <u>10 16 1966</u>	
5. SEX <u>F</u>	6. COLOR OR RACE <u>W</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>11-20-82</u>
9. AGE (In years last birthday) <u>83</u> yrs		10. IF UNDER 1 YEAR Months Days Hours Min. <u>10 26</u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Unknown</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>housewife</u>	
11. BIRTHPLACE (County & State, or foreign country) <u>Unknown Salisbury, Md.</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>George Washington Hastings</u>		14. MOTHER'S MAIDEN NAME <u>Eliza Jane Hitch</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <u>No</u>		16. SOCIAL SECURITY NO <u>217-54-5647</u>	
17. INFORMANT <u>Mrs. Alice W. Parker</u>		Address <u>Salisbury, Md. Eastern Shore State Hosp. Baker St.</u>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Pulmonary embolism</u> DUE TO (b) <u>Thrombosis of R.V. femoral vein</u> DUE TO (c) <u>URI</u>			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>None</u>			
19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <u>N/A</u>	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <u>19</u>	20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work at work	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that (I) (this hospital) attended the deceased from <u>8-65</u> , 19 <u>65</u> , to <u>10-16</u> , 19 <u>66</u> ; that (I) (we) last saw the deceased alive on <u>10-16-66</u> , and that death occurred at <u>10:30</u> a.m., from causes and on the date stated above			
22a. SIGNATURE <u>B. W. Rieckert</u>		22b. DATE SIGNED <u>10-17-66</u>	
22c. PHYSICIAN'S NAME (Type) <u>B. W. Rieckert</u>		22d. ADDRESS <u>E-New Market Rd</u>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	23b. DATE THEREOF <u>Oct. 19, 1966</u>	23c. NAME OF CEMETERY OR CREMATORY <u>Parsons Cemetery</u>	23d. LOCATION (City or Town) (County) (State) <u>Salisbury, Maryland</u>
24. FUNERAL DIRECTOR <u>HOLLOWAY &amp; COMPANY, SALISBURY, MARYLAND</u>		25a. REC'D BY REGISTRAR DATE <u>OCT 24 1966</u>	25b. REGISTRAR'S SIGNATURE <u>Charles Judge</u>



TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

FOR STATE  
HEALTH DEPT.

VR A15ME (5)  
SM 1/65

MARYLAND STATE DEPARTMENT OF HEALTH  
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND  
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

1. PLACE OF DEATH a. COUNTY <b>DORCHESTER</b> b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <b>RURAL CAMBRIDGE</b> c. LENGTH OF STAY IN ID <b>2 YRS.</b> d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <b>EASTERN SHORE STATE HOSPITAL</b>		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <b>MD.</b> b. COUNTY <b>CAROLINE</b> ✓ c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <b>DENTON, RT. 1</b> d. STREET ADDRESS e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <b>LULA</b> Middle <b>BELL</b> Last <b>PUSEY</b>		4. DATE OF DEATH Month <b>OCTOBER</b> Day <b>11</b> Year <b>1966</b>	
5. SEX <b>FEMALE</b>	6. COLOR OR RACE <b>WHITE</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>7/9/87</b>
9. AGE (in years last birthday) <b>79 yrs.</b>		IF UNDER 1 YEAR Months <b>79</b> Days <b>11</b> Hours <b>19</b> Min. <b>66</b>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (State or foreign country) <b>MD.</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.</b>	
13. FATHER'S NAME <b>JAMES R. THOMPSON</b>		14. MOTHER'S MAIDEN NAME <b>VICTORIA POWELL</b>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <b>NO</b>		16. SOCIAL SECURITY NO. <b>220-12-0635</b>	
17. INFORMANT <b>HOSPITAL RECORDS</b>		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Bronchopneumonia</b> 70477 Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b>Fracture of left femur</b> DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
INTERVAL BETWEEN ONSET AND DEATH			
19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
20a. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> OR CONTRIBUTING CAUSE OF DEATH <input type="checkbox"/>		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of Item 18.) <b>Fell in Hospital</b>	
20c. TIME OF INJURY Month, Day, Year Hour <b>7</b> a.m. <b>21</b> 19 <b>66</b> p.m.		20d. INJURY OCCURRED While <input checked="" type="checkbox"/> at work Not While <input type="checkbox"/> at work	
20e. PLACE OF INJURY Home, farm, factory, street, office bldg., etc.) <b>Eastern Shore State Hospital Cambridge Md.</b>		20f. (City or town) (County) (State)	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE <b>Pete W Rieckert</b>		M.D. ASSISTANT MEDICAL EXAMINER <input checked="" type="checkbox"/>	
EXAMINER'S NAME (Type) <b>Pete W Rieckert</b>		DEPUTY MEDICAL EXAMINER <input type="checkbox"/>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial Oct. 16, 1966</b>		23b. DATE THEREOF <b>Oct. 16, 1966</b>	
23c. NAME OF CEMETERY OR CREMATORY <b>Denton</b>		23d. LOCATION (City, town or county) (State) <b>Denton Md.</b>	
24. FUNERAL DIRECTOR <b>Charles V. Moore</b>		ADDRESS <b>Denton, Md.</b>	
25a. REC'D BY REGISTRAR <b>Charles Judge</b>		25b. REGISTRAR'S SIGNATURE <b>Charles Judge</b>	
DATE <b>OCT 20 1966</b>			



TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If city delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

VR A15ME (3)  
6M 1/66

FOR STATE  
HEALTH DEPT.

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

14111

14112

1 PLACE OF DEATH a. COUNTY <b>DORCHESTER</b> MARYLAND				2 USUAL RESIDENCE (Where deceased lived, if institution Residence before admission) a. STATE <b>MARYLAND</b> b. COUNTY <b>WICOMICO</b>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>RURAL CAMBRIDGE</b>			c. LENGTH OF STAY IN 1b <b>11 YRS.</b>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>PITTSVILLE</b>		
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>EASTERN SHORE STATE HOSPITAL</b>				d. STREET ADDRESS		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <b>JOHN</b> Middle <b>WALTER</b> Last <b>SHOCKLEY</b>			4 DATE OF DEATH Month <b>OCTOBER</b> Day <b>11</b> Year <b>1966</b>				
5. SEX <b>MALE</b>	6. COLOR OR RACE <b>WHITE</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>10/22/10</b>		9 AGE (In years last birthday) yrs. <b>53</b>	IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Laborer</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Processing Plant Md.</b>		11 BIRTHPLACE (State or foreign country)		12 CITIZEN OF WHAT COUNTRY? <b>U.S.</b>	
13 FATHER'S NAME <b>GEORGE A. SHOCKLEY</b>			14 MOTHER'S M A DEN NAME <b>MINNIE L. DENNIE</b>				
15 WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service)		16 SOCIAL SECURITY NO		17 INFORMANT <b>HOSPITAL RECORDS</b>			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Asphyxia</b> DUE TO (b) <b>Aspiration of food</b> DUE TO (c) Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last						INTERVAL BETWEEN ONSET AND DEATH <b>Instant</b>	
PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b>Chronic brain syndrome.</b>						19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
20a. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18) <b>Choked while eating.</b>					
20c. TIME OF INJURY Month, Day Year <b>1:15 PM 10/11/66</b>		20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input checked="" type="checkbox"/> of work	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <b>Hospital</b>		20f. (City or town) (County) (State) <b>Cambridge, Dor. Md.</b>		
21. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> , Inspection <input type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and in my opinion death resulted from: Natural causes <input type="checkbox"/> , Accident <input checked="" type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/>							
ACTUAL SIGNATURE  EXAMINER'S NAME (Type) <b>John Mace Jr. M.D.</b>		22. DATE SIGNED <b>1/5/67</b>		CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/> Address (Street, city, town, or county) <b>Cambridge, Md.</b>			
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		23b. DATE THEREOF <b>10/14/66</b>		23c. NAME OF CEMETERY OR CREMATORY <b>Pittsville Cemetery</b>		23d. LOCATION (City or Town) (County) (State) <b>Pittsville, Wic. Md.</b>	
24. FUNERAL DIRECTOR <b>Holloway &amp; Co. Salisbury, Md.</b>				25a. REC'D BY REGISTRAR DATE <b>JAN 10 1967</b>		25b. REGISTRAR'S SIGNATURE 	

Helmi G384 - 1/10/67. MB

Originally reported on regular death certificate form  
and should have been on M.E. form.

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

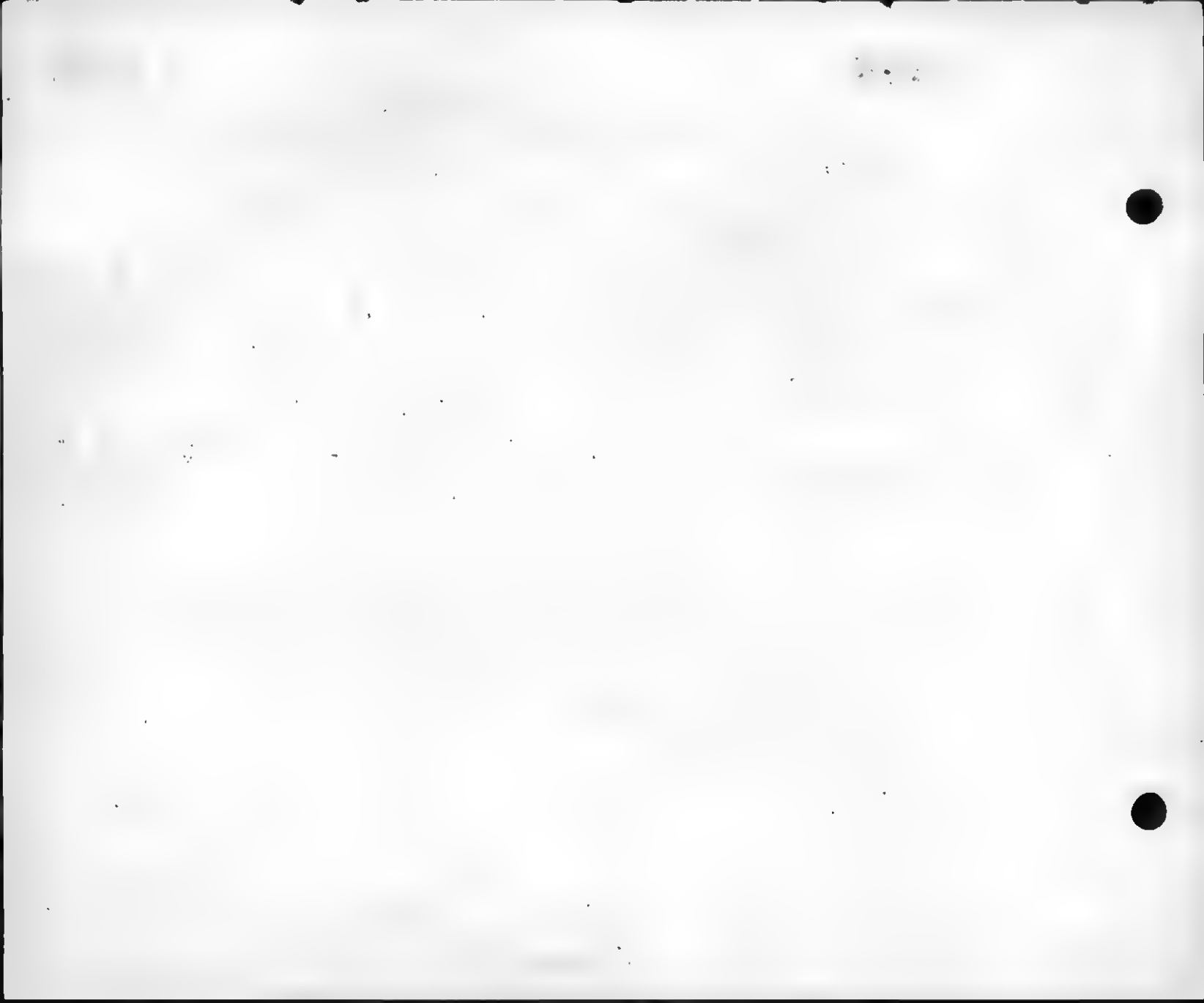
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. They please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND  
CERTIFICATE OF DEATH

15512

15603

1. PLACE OF DEATH a. COUNTY <u>DORCHESTER</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived, if Institution: Residence before admission) a. STATE <u>MARYLAND</u> b. COUNTY <u>T</u>			
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>CAMBRIDGE</u>		c. LENGTH OF STAY IN 1b		c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>TRAPPE</u>		d. STREET ADDRESS <u>Rt. 2 Box 8</u>	
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <u>CAMBRIDGE HOSPITAL</u>				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First <u>LEWIS</u> Middle <u>A.</u> Last <u>SMITH</u>		4. DATE OF DEATH Month <u>10</u> Day <u>16</u> Year <u>1966</u>		5. SEX <u>MALE</u>		6. COLOR OR RACE <u>COLORED</u>	
7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>FEB. 15, 1886</u>		9. AGE (in years last birthday) <u>80</u> yrs.		IF UNDER 1 YEAR Months <u>  </u> Days <u>  </u> Hours <u>  </u> Min. <u>  </u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Laborer</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>DOMESTIC</u>		11. BIRTHPLACE (County & State, or foreign country) <u>Talbot, Md</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>JOSEPH H SMITH</u>				14. MOTHER'S MAIDEN NAME <u>MARY MANDY</u>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>NO</u>		16. SOCIAL SECURITY NO. <u>214-32-2373</u>		17. INFORMANT <u>Hospital Records</u>		Address <u>CAMBRIDGE MD</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c.)] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Coronary occlusion</u> <u>4201</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Coronary Heart Disease</u> DUE TO (c) <u>Generalized Arteriosclerosis</u>							INTERVAL BETWEEN ONSET AND DEATH <u>5 min</u> <u>5 yrs</u> <u>10 yrs</u>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)							19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of Item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour a.m. <u>  </u> p.m. <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from <u>10/4/66</u> , 19 <u>66</u> , to <u>10/16</u> , 19 <u>66</u> , that (I) (we) last saw the deceased alive on <u>10/16</u> , 19 <u>66</u> , and that death occurred at <u>2:47</u> M. from the causes and on the date stated above.							
22a. SIGNATURE <u>Lawrence Maryanov</u>				ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22b. DATE SIGNED <u>11/4/66</u>	
22c. PHYSICIAN'S NAME (Type) <u>Lawrence Maryanov</u>				22d. ADDRESS <u>610 Race St. Cambridge, Md</u>			
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>		23b. DATE THEREOF <u>10-21-66</u>		23c. NAME OF CEMETERY OR CREMATORY <u>PARADISE CEMETERY</u>		23d. LOCATION (City, town or county) (State) <u>TRAPPE MD</u>	
24. FUNERAL DIRECTOR <u>GEORGE H. Maschell</u>				25a. REC'D BY REGISTRAR <u>Easton, Md.</u>		25b. REGISTRAR'S SIGNATURE <u>Charles Judge</u>	



1

M

FOR STATE HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

14113

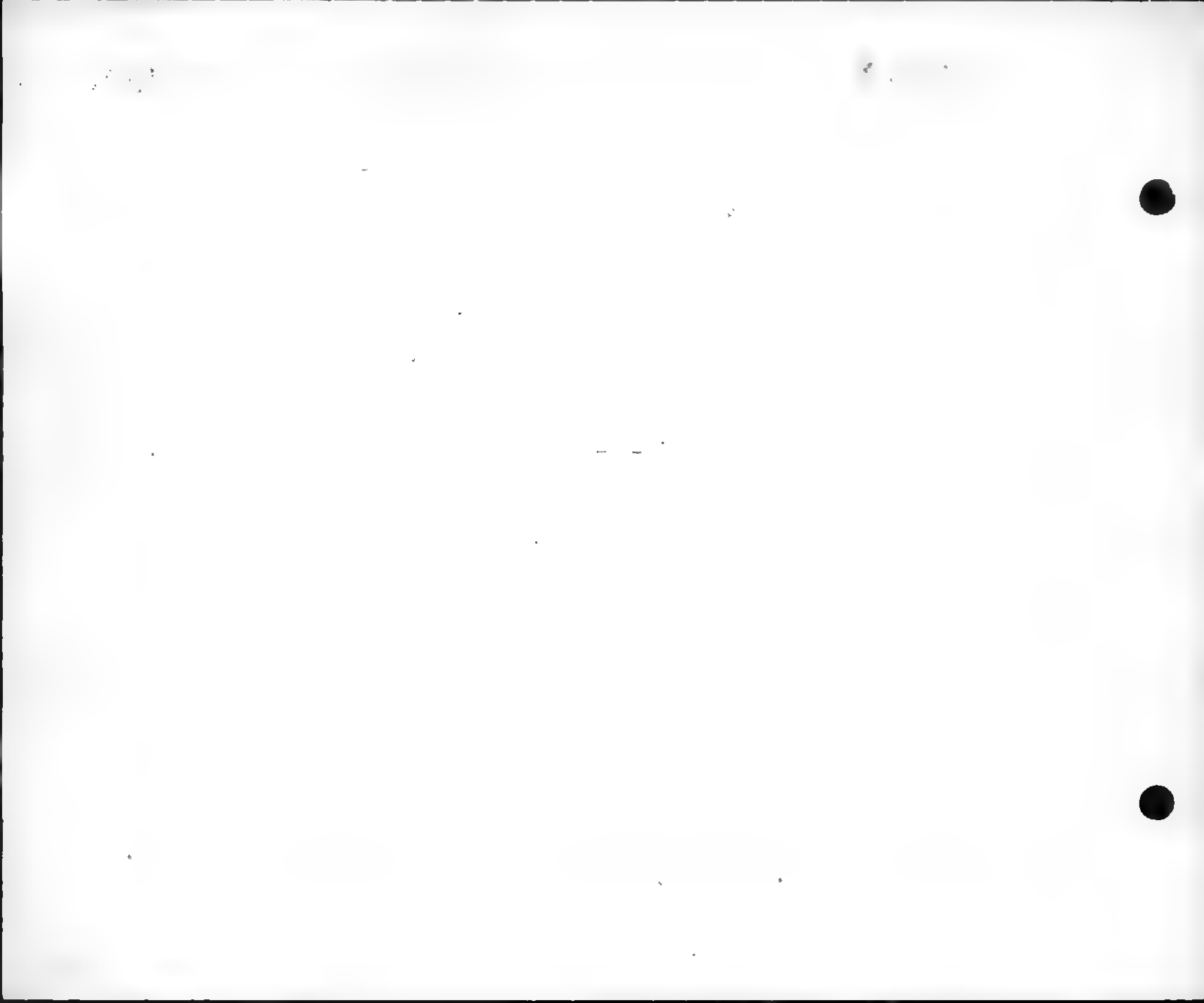
MARYLAND STATE DEPARTMENT OF HEALTH

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

14113

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

1 PLACE OF DEATH a. COUNTY <b>Dorchester</b> MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution. Residence before admission) a STATE <b>Maryland</b> b COUNTY <b>Dorchester</b>	
b CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Rural-Cambridge</b>		c LENGTH OF STAY & 1b <b>20 years</b>	
d NAME OF HOSPITAL OR INSTITUTION (If not in hosp to give street address) <b>Town Point RFD # 3</b>		d STREET ADDRESS <b>Town Point RFD # 3</b>	
3 NAME OF DECEASED (Type or print) First <b>LOUIS</b> Middle <b>WILLIAM</b> Last <b>SNOWDEN</b>		4 DATE OF DEATH Month <b>October</b> Day <b>15</b> Year <b>1966</b>	
5 SEX <b>Male</b>	6 COLOR OR RACE <b>White</b>	7 MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8 DATE OF BIRTH <b>Oct. 15, 1883</b>
9 AGE (In years lost birthday yrs) <b>83</b>		10 IF UNDER 1 YEAR Months <b>83</b> Days <b>83</b> Hours <b>83</b> Min <b>83</b>	
11 USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Mechanic</b>		12 KIND OF BUSINESS OR INDUSTRY <b>Motor</b>	
13 BIRTHPLACE (State or foreign country) <b>Latvia</b>		14 CITIZEN OF WHAT COUNTRY? <b>USA</b>	
15 FATHER'S NAME <b>Unknown</b>		16 MOTHER'S MAIDEN NAME <b>Unknown</b>	
17 WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <b>Unk</b> <b>Unk</b>		18 SOCIAL SECURITY NO. <b>075-10-3184</b>	
19 INFORMANT <b>Stuart L. Snowden, Scarsdale, N. Y.</b>		Address	
19. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Coronary occlusion</b> 42:1 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <b>Arteriosclerotic Ht. Disease</b> DUE TO (c) PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) <b>Myeloid splenic metaplasia</b>			
19 WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING CAUSE OF DEATH <input type="checkbox"/>		20b DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 1b)	
20c TIME OF INJURY Month, Day, Year Hour a.m. <b>19</b> p.m.		20d INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work at work	
20e PLACE OF INJURY (Home, farm, factory, street, office bldg., etc)		20f (City or town) (County) (State)	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from. Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE <b>Alfred R. Maryanov</b> M.D.		CHIEF MEDICAL EXAMINER <input type="checkbox"/>	
EXAMINER'S NAME (Type) <b>Alfred R. Maryanov, MD</b>		ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>	
22. DATE SIGNED <b>10/17/66</b>		DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/> <b>610 Race St.</b>	
23a BURIAL (CREMATION, REMOVAL) (Specify)		23b DATE THEREOF	
<b>Cremation</b>		<b>Oct 17 1966</b>	
23c NAME OF CEMETERY OR CREMATORY		23d LOCATION (City or Town) (County) (State)	
<b>Lee Funeral Home</b>		<b>Washington, D. C.</b>	
24 FUNERAL DIRECTOR <b>LeCompte Funeral Service, Cambridge, Maryland</b>		25a REC'D BY REGISTRAR <b>DATE OCT 18 1966</b>	
ADDRESS		25b REGISTRAR'S SIGNATURE <b>Charles Judge</b>	



# MARYLAND STATE DEPARTMENT OF HEALTH

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

## CERTIFICATE OF DEATH

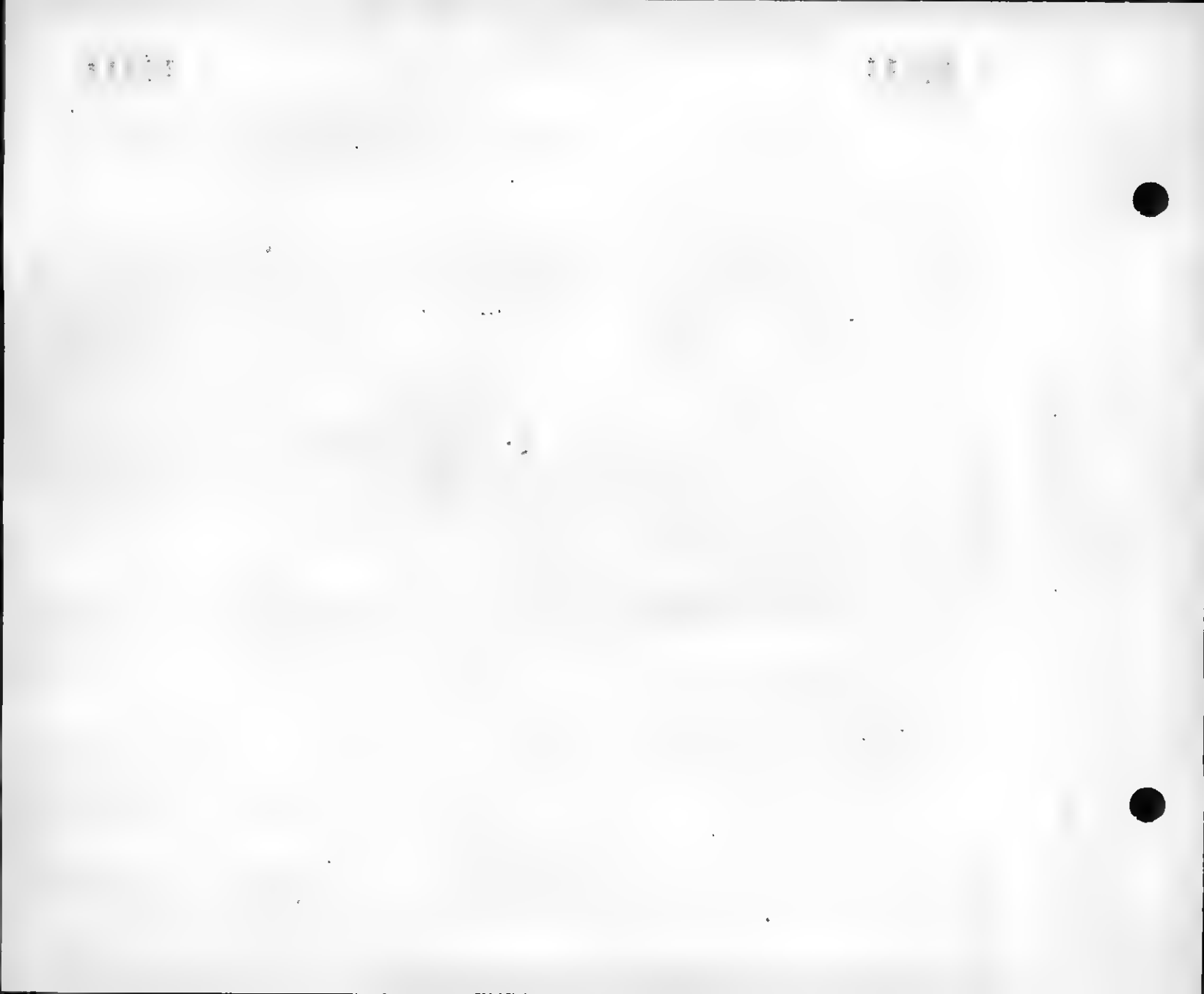
14114

14114

1. PLACE OF DEATH a. COUNTY <u>Dorchester</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived, if institution Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Dorchester</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Rural - Cambridge</u>				c. LENGTH OF STAY IN 1b <u>14.42.5 days</u>			
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Hurlock</u>				d. STREET ADDRESS			
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Eastern Shore State Hospital</u>				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) <u>Ethel</u> <u>Millie</u> <u>Spencer</u>				4. DATE OF DEATH Month <u>Oct.</u> Day <u>21</u> Year <u>1966</u>			
5. SEX <u>Female</u>	6. COLOR OR RACE <u>Negro</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>July 11, 1882</u>		9. AGE (In years lost birthday) <u>84</u> yrs	10. IF UNDER 1 YEAR Months <u>  </u> Days <u>  </u> Hours <u>  </u> Min <u>  </u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Home</u>		11. BIRTHPLACE (County & State, or foreign country) <u>Maryland</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>Wesley Cornish</u>				14. MOTHER'S M maiden NAME <u>Hester</u>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <u>unknown</u>		16. SOCIAL SECURITY NO. <u>unknown</u>		17. INFORMANT <u>Med. Records</u> Address <u>Eastern Shore State Hospital</u>			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Myocardial infarction</u> DUE TO <u>Arteriosclerotic heart disease</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost (b) <u>  </u> DUE TO (c) <u>  </u>							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>  </u>							
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <u>  </u>			
20c. TIME OF INJURY Month, Day, Year <u>10-21-66</u>		20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <u>  </u>		20f. (City or town) (County) (State) <u>  </u>	
21. I certify that (I) (this hospital) attended the deceased from <u>06-16</u> , 19 <u>65</u> , to <u>10-21</u> , 19 <u>66</u> , that (I) (we) last saw the deceased alive on <u>10-21</u> 19 <u>66</u> , and that death occurred at <u>2:15</u> P, from causes and on the date stated above.							
22a. SIGNATURE <u> Felipe M. Dominguez</u> M.D.				ATTENDING PHYS. <input type="checkbox"/> MED. DIRECTOR <input checked="" type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22b. DATE SIGNED <u>10-21-66</u>	
22c. PHYSICIAN'S NAME (Type) <u>FELIPE M. DOMINGUEZ</u>				22d. ADDRESS <u>ESS 14</u>			
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		23b. DATE THEREOF <u>Oct. 29, 1966</u>		23c. NAME OF CEMETERY OR CREMATORY <u>Washington Cemetery</u>		23d. LOCATION (City or Town) (County) (State) <u>Near Hurlock, Maryland</u>	
24. FUNERAL DIRECTOR <u>Truaxton Funeral Home Frederick, Md.</u>				25a. REC'D BY REGISTRAR DATE <u>OCT 27 1966</u>		25b. REGISTRAR'S SIGNATURE <u>Charles Judge</u>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.



# MARYLAND STATE DEPARTMENT OF HEALTH

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

Item #1d Film #3332 10/27/66 ps

## MEDICAL EXAMINER'S CERTIFICATE OF DEATH

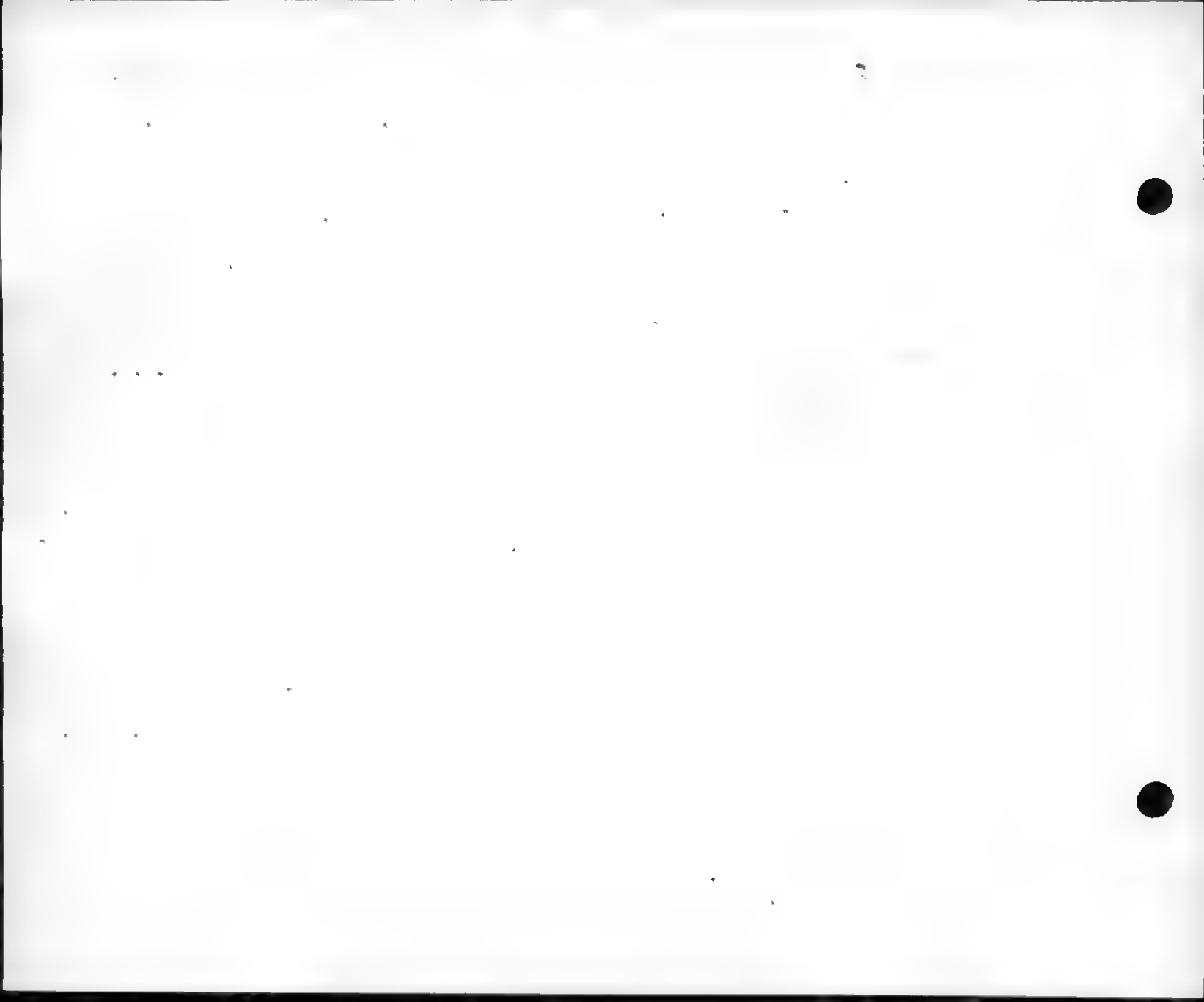
14115

FOR STATE  
HEALTH DEPT

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health or its designated agent, prior to burial, cremation, or removal, and for any event within 72 hours after death.

1. PLACE OF DEATH a. COUNTY <b>Dorchester</b>		2. USUAL RESIDENCE (Where deceased lived, if institution. Residence before admission) a. STATE <b>Md.</b> b. COUNTY <b>Dor.</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Cambridge</b>		c. LENGTH OF STAY IN 1b <b>1 Mo.</b>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>Cambridge Hospital</b>		e. STREET ADDRESS <b>Glenburn Ave. 82 Travers St.</b>	
3. NAME OF DECEASED (Type or print) <b>Rebecca Squires</b>		4. DATE OF DEATH Month <b>Oct.</b> Day <b>18</b> Year <b>66</b>	
5. SEX <b>F</b>	6. CO. OR RACE <b>W</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>? 1876</b>
9. AGE (in years or birthday) <b>90</b>		10. UNDER 1 YEAR Months <b>1</b> Days <b>18</b> Hours <b>19</b> Min <b>66</b>	
10a. USUAL OCCUPATION (Give kind of work done during last working life, even if retired) <b>None</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Indiana</b>	
11. BIRTHPLACE (State or foreign country) <b>Indiana</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
13. FATHER'S NAME <b>Rubin Squires</b>		14. MOTHER'S MAIDEN NAME <b>Unknown</b>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <b>No</b>		16. SOCIAL SECURITY NO <b>---</b>	
17. INFORMANT <b>Cambridge Hospital Records</b>		Address	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) DUE TO <b>Congestive heart failure</b> Conditions (only which gave rise to immediate cause (a), stating the underlying cause lost) (b) <b>Fracture neck r. femur</b> DUE TO (c)			INTERVAL BETWEEN ONSET AND DEATH <b>1 wk.</b> <b>33 days</b>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING CAUSE OF DEATH <input checked="" type="checkbox"/> <b>Fell while walking in Nursing Home.</b>		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18)	
20c. TIME OF INJURY Month, Day, Year <b>3PM</b> Hour a.m. <b>9-15-66</b> p.m.		20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input checked="" type="checkbox"/> at work	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <b>Nursing Home</b>		20f. (City or town) (County) (State) <b>Cambridge Dor. Md.</b>	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE <b>John Mace Jr.</b>		22. DATE SIGNED <b>10/18/66</b>	
EXAMINER'S NAME (Type) <b>John Mace Jr.</b>		Address (Street, city, town, or county)	
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>	23b. DATE THEREOF <b>Oct 21 1966</b>	23c. NAME OF CEMETERY OR CREMATORY <b>Fairview Cemetery</b>	23d. LOCATION (City or Town) (County) (State) <b>Linton, Indiana</b>
24. FUNERAL DIRECTOR <b>LeCompte Funeral Service, Cambridge, Maryland</b>		25a. REC'D BY REG. STR. DATE <b>OCT 19 1966</b>	
25b. REGISTERING SIGNATURE <b>John Mace Jr.</b>		25c. REGISTERING SIGNATURE <b>John Mace Jr.</b>	



MARYLAND STATE DEPARTMENT OF HEALTH

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

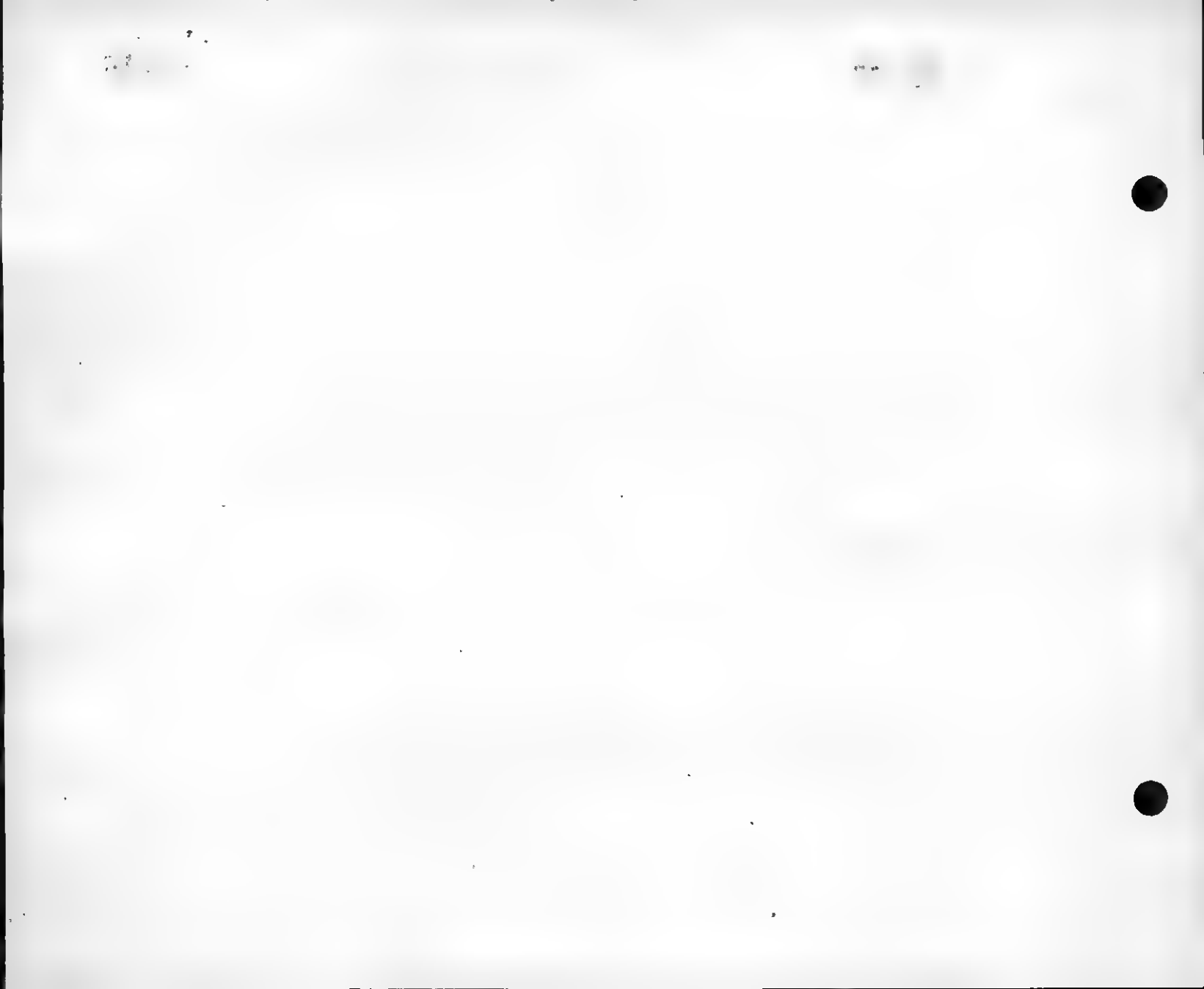
CERTIFICATE OF DEATH

14116

13116

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

1. PLACE OF DEATH a. COUNTY <u>Dorchester</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution. Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Dorchester</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>CAMBRIDGE</u>		c. LENGTH OF STAY IN 1b <u>3 yrs 1 mo</u>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>EASTERN SHORE STATE HOSPITAL</u>		d. STREET ADDRESS	
3. NAME OF DECEASED (Type or print) <u>Josephine Stanley</u>		4. DATE OF DEATH <u>Oct. 30 1966</u>	
5. SEX <u>FEMALE</u>	6. COLOR OR RACE <u>NEGRO</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>1893 (?)</u>
9. AGE (In years last birthday) <u>73 yrs</u>		10. IF UNDER 24 HRS. Months Days Hours Min	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>House wife</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Home</u>	
11. BIRTHPLACE (County & State, or foreign country) <u>Virginia</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>Unknown</u>		14. MOTHER'S MAIDEN NAME <u>Palmer, Louise</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>		16. SOCIAL SECURITY NO. <u>220-01-5639</u>	
17. INFORMANT <u>Eastern Shore State Hospital - Medical Records</u>		Address	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <u>Generalized arteriosclerosis</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>444X</u> (c) <u>Essential Hypertension</u>		INTERVAL BETWEEN ONSET AND DEATH	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Essential Hypertension</u>		19. WAS A TOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from <u>Sept 6, 1963</u> to <u>Oct. 30, 1966</u> that <u>we</u> last saw the deceased alive on <u>Oct. 30, 1966</u> , and that death occurred at <u>9:15 P.M.</u> from causes and on the date stated above.			
22a. SIGNATURE <u>Edward Lewis Jr. M.D.</u>		22b. DATE SIGNED <u>10/30/66</u>	
22c. PHYSICIAN'S NAME (Type) <u>EDWARD LEWIS JR., MD</u>		22d. ADDRESS <u>5800 BEECH AVE. BETHESDA MD.</u>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		23b. DATE THEREOF <u>Nov. 1, 1966</u>	
23c. NAME OF CEMETERY OR CREMATORY <u>East New Market Cemetery</u>		23d. LOCATION (City or Town) (County) (State) <u>East New Market, Dorchester Md.</u>	
24. FUNERAL DIRECTOR <u>From Transp. Co. Federalburg, Maryland</u>		25a. REC'D BY REGISTRAR <u>NOV 4 1966</u>	
25b. REGISTRAR'S SIGNATURE <u>Charles Judge</u>			



MARYLAND STATE DEPARTMENT OF HEALTH

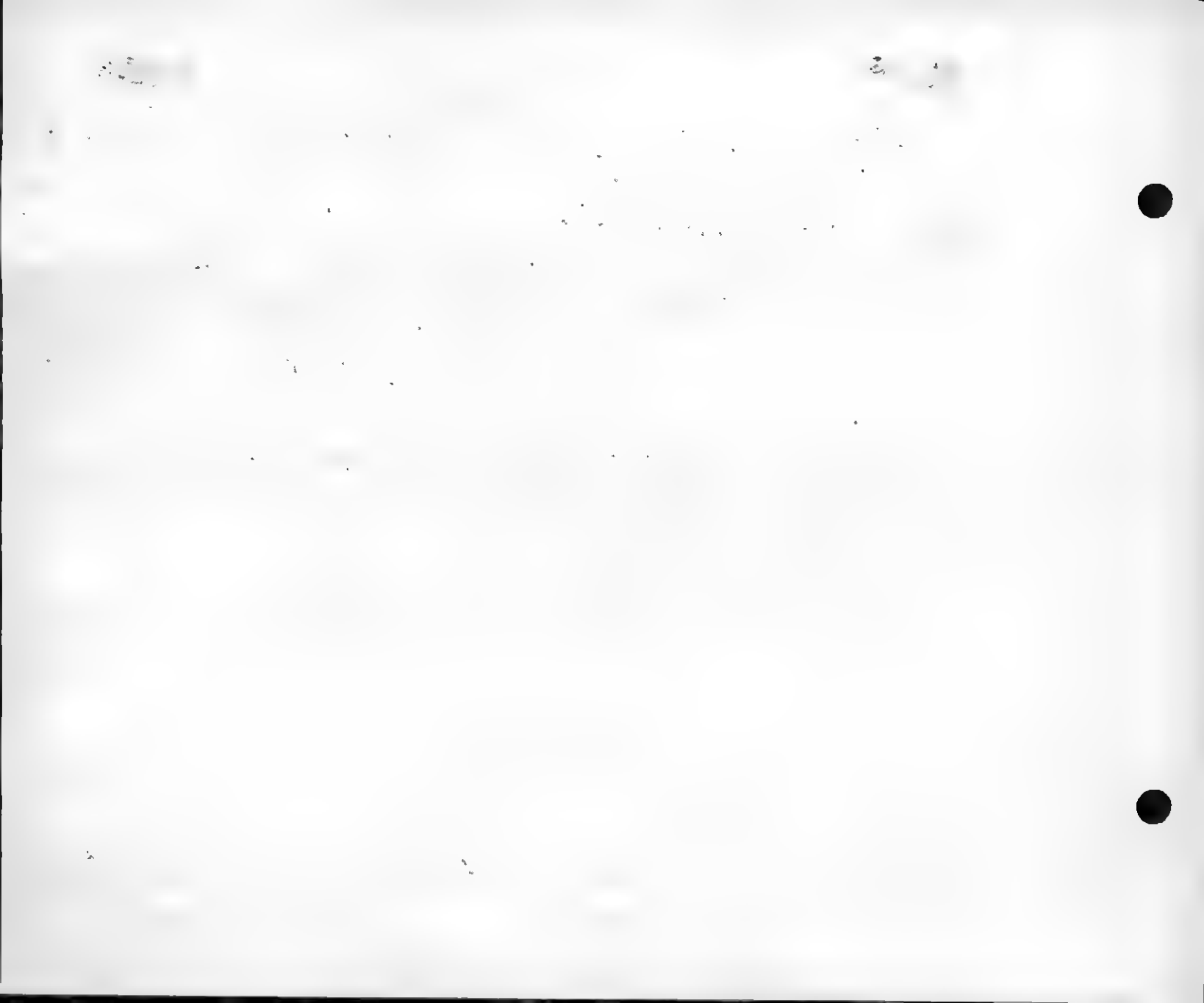
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

CERTIFICATE OF DEATH

1. PLACE OF DEATH a. COUNTY <u>Dorchester</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived if institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Caroline</u>	
b. CITY OR TOWN (If outside corporate limits write RURAL and give nearest town) <u>Cambridge (Rural) 2m.</u>		c. CITY OR TOWN (If outside corporate limits write RURAL and give nearest town) <u>Ridgely</u>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Eastern Shore State Hosp.</u>		d. STREET ADDRESS <u>None</u>	
3. NAME OF DECEASED (Type or print) <u>Harry Taylor</u>		4. DATE OF DEATH Month <u>Oct</u> Day <u>5</u> Year <u>1966</u>	
5. SEX <u>F</u>	6. COLOR OR RACE <u>N</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>May 6, 1898</u>
9. AGE (In years birth day) <u>68 1/2</u> yrs		10. IF UNDER 1 YEAR Months <u>—</u> Days <u>—</u> Hours <u>—</u> Min <u>—</u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>—</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>—</u>	
11. BIRTHPLACE (County & State, or foreign country) <u>Maryland</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>James S. Scribner</u>		14. MOTHER'S MAIDEN NAME <u>Liza Jackson</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <u>Unknown</u>		16. SOCIAL SECURITY NO. <u>218-20-4494</u>	
17. INFORMANT <u>Records - Hospital</u>		Address <u>—</u>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Carcinoma of Mediastinum</u> DUE TO (b) <u>—</u> DUE TO (c) <u>—</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.			INTERVAL BETWEEN ONSET AND DEATH <u>months</u>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Chronic Brain Syndrome</u>			19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <u>None</u>	
20c. TIME OF INJURY Month, Day, Year Hour a.m. <u>19</u> p.m. <u>—</u>	20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work at work	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc)	20f. (City or town) (County) (State)
21. I certify that <u>(H)</u> (this hospital) attended the deceased from <u>8-1-66</u> , 19 <u>—</u> , to <u>10-5-66</u> , 19 <u>—</u> , that <u>(H)</u> (we) last saw the deceased alive on <u>10-5-1966</u> , and that death occurred at <u>6:14</u> A.M., from causes and on the date stated above.			
22a. SIGNATURE <u>John B. Webster</u>		22b. DATE SIGNED <u>10-5-66</u>	
22c. PHYSICIAN'S NAME (Type) <u>John B. Webster</u>		22d. ADDRESS <u>Eastern Shore State Hosp.</u>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	23b. DATE THEREOF <u>Oct. 7, 66</u>	23c. NAME OF CEMETERY OR CREMATORY <u>Denton</u>	23d. LOCATION (City or Town) (County) (State) <u>Denton, Maryland</u>
24. FUNERAL DIRECTOR <u>John E. Boudous Greenbaum Inc.</u>		25a. REC'D BY REGISTRAR <u>Charles Judge</u>	
25b. REGISTRAR'S SIGNATURE		DATE <u>OCT 10 1966</u>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that this certificate be examined within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. When please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)  
15M 4-64

MARYLAND STATE DEPARTMENT OF HEALTH DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND									
14118 14118 CERTIFICATE OF DEATH					14118				
1. PLACE OF DEATH a. COUNTY <u>Dorchester</u> MARYLAND					2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <u>MD</u> b. COUNTY <u>Dor</u>				
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Hurlock</u>			c. LENGTH OF STAY IN 1b <u>2 yrs</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>East New Market</u>				
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Belle Haven Nursing Home</u>					d. STREET ADDRESS			e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <u>Edna Pauline Thomas</u>			First Middle Last		4. DATE OF DEATH Month <u>10</u> Day <u>3</u> Year <u>1966</u>				
5. SEX <u>Female</u>		6. COLOR OR RACE <u>white</u>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>8/5/1895</u>		9. AGE (In years last birthday) <u>71</u> yrs. IF UNDER 1 YEAR Months Days IF UNDER 24 HRS. Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>None</u>			10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (County & State, or foreign country) <u>Maryland</u>			12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>Hubert W. Bounds</u>					14. MOTHER'S MAIDEN NAME <u>Elizabeth Malone</u>				
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>			16. SOCIAL SECURITY NO.		17. INFORMANT Address <u>Mrs Leland Beckwith, Jr. East New Market</u>				
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Chronic Coriary Arteriosclerosis &amp; Coronary Sclerosis</u> DUE TO (b) <u>Generalized Atherosclerosis</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (c) OUE TO PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Bilateral Hemiplegia following Severe Stroke Mellitus</u>									INTERVAL BETWEEN ONSET AND DEATH <u>2 yrs</u> <u>10 yrs</u>
20a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)						
20c. TIME OF INJURY Month, Day, Year Hour a.m. <u>7:15</u> p.m. <u>1966</u>			20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)		
21. I certify that (I) (this hospital) attended the deceased from <u>10/20</u> , 19 <u>65</u> , to <u>10/3</u> , 19 <u>66</u> , that (I) (we) last saw the deceased alive on <u>10/3</u> , 19 <u>66</u> , and that death occurred at <u>4:30 PM</u> , from the causes and on the date stated above.									
22a. SIGNATURE <u>James B. Plummer</u>					M.D. ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22b. DATE SIGNED		
22c. PHYSICIAN'S NAME (Type) <u>Harold B. Plummer M.D.</u>					22d. ADDRESS <u>Preston Maryland</u>				
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		23b. DATE THEREOF <u>10/5/66</u>		23c. NAME OF CEMETERY OR CREMATORY <u>East New Market</u>			23d. LOCATION (City, town or county) (State) <u>East New Market MD</u>		
24. FUNERAL DIRECTOR <u>Ruth A. Holloway, East New Market, MD</u>					25a. REC'D BY REGISTRAR DATE <u>OCT 7 1966</u>		25b. REGISTRAR'S SIGNATURE <u>Charles Judge</u>		



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)  
20 M 1/66

14119

14119

MARYLAND STATE DEPARTMENT OF HEALTH  
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

CERTIFICATE OF DEATH

1. PLACE OF DEATH a. COUNTY <b>Dorchester</b> MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution. Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Talbot</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Cambridge</b>		c. LENGTH OF STAY IN 1b <b>2 wks.</b>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>Cambridge Maryland Hospital</b>		d. STREET ADDRESS <b>McDaniel</b>	
3. NAME OF DECEASED (Type or print) First <b>James</b> Middle <b>Thomas</b> Last <b>Thomas</b>		4. DATE OF DEATH Month <b>October</b> Day <b>25</b> Year <b>19 66</b>	
5. SEX <b>Male</b>	6. COLOR OR RACE <b>Negro</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>Mar. 18, 1910</b>
9. AGE (n years last birthday) <b>56</b> yrs		10. IF UNDER 1 YEAR Months <b>56</b> Days <b>56</b> Hours <b>56</b> Min. <b>56</b>	
10a. US. AL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Laborer</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Truck Driver</b>	
11. BIRTHPLACE (County & State or foreign country) <b>Dorchester Co., Md.</b>		12. CITIZEN OF WHAT COUNTRY? <b>USA</b>	
13. FATHER'S NAME <b>George Ross</b>		14. MOTHER'S MAIDEN NAME <b>Arenda Ennels</b>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <b>No</b>		16. SOCIAL SECURITY NO <b>221-05-9958</b>	
17. INFORMANT <b>Jennie Wilkins</b>		Address <b>Cambridge, Md.</b>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Peritonitis</b> <b>5501</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b>Ruptured Appendicitis</b> DUE TO (c) <b>15 days</b>			INTERVAL BETWEEN ONSET AND DEATH <b>15 days</b>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)			19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. <b>19</b> p.m.	20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work at work	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that (I) (this hospital) attended the deceased from <b>10-10-</b> , 1966, to <b>10-25-</b> , 1966, that (I) (we) last saw the deceased alive on <b>10-25-</b> , 1966, and that death occurred at <b>10-25-</b> , 1966, from causes and on the date stated above.			
22a. SIGNATURE <b>J. Edwin Fassett</b>		22b. DATE SIGNED <b>Oct. 27, 1966</b>	
22c. PHYSICIAN'S NAME (Type) <b>J. Edwin Fassett, M.D.</b>		22d. ADDRESS <b>727 Pine Street Cambridge, Md.</b>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>	23b. DATE THEREOF <b>10/28/66</b>	23c. NAME OF CEMETERY OR CREMATORY <b>Bethel</b>	23d. LOCATION (City or Town) (County) (State) <b>Cambridge Dor. Md.</b>
24. FUNERAL DIRECTOR <b>Frederick C. Blair</b>		25a. REC'D BY REGISTRAR <b>Charles Judae</b>	
ADDRESS <b>Cambridge, Md.</b>		DATE <b>OCT 28 1966</b>	

111

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

1  
M

**MARYLAND STATE DEPARTMENT OF HEALTH**  
**DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND**  
**CERTIFICATE OF DEATH**

14120

14120

1. PLACE OF DEATH a. COUNTY <b>Dorchester</b>			2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Dorchester</b>		
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Cambridge</b>			c. LENGTH OF STAY IN <b>MARYLAND</b> <b>3 days</b>		
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>Cambridge Maryland Hospital</b>			e. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Rural-Cambridge</b>		
3. NAME OF DECEASED (Type or print) First <b>R.</b> Middle <b>STERLING</b> Last <b>THOMAS</b>			4. DATE OF DEATH Month <b>Oct.</b> Day <b>24,</b> Year <b>1966</b>		
5. SEX <b>Male</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/>	8. DATE OF BIRTH <b>Feb. 13, 1902</b>		9. AGE (In years last birthday) <b>64</b> yrs. IF UNDER 1 YEAR Months Days IF UNDER 24 HRS. Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Tool Maker</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Electronics</b>		11. BIRTHPLACE (County & State, or foreign country) <b>York, Penna.</b>	
13. FATHER'S NAME <b>Charles F. Thomas</b>			12. CITIZEN OF WHAT COUNTRY? <b>USA</b>		
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <b>Unk</b>			16. SOCIAL SECURITY NO. <b>201-07-5059</b>		17. INFORMANT <b>Miss Luise Thomas, York, Penna.</b>
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Cerebrovascular Accident</b> DUE TO Conditions, if any, which gave rise to immediate cause (e), stating the underlying cause last. } DUE TO (b) <b>Generalized Arteriosclerosis</b> (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b>Diabetes Mellitus</b>					INTERVAL BETWEEN ONSET AND DEATH <b>2 days</b> <b>1 yr.</b>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)					19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>
20c. TIME OF INJURY Hour <b>a.m.</b> <b>19</b> p.m.		20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> of work <input type="checkbox"/> of work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town)		20g. (County)		20h. (State)	
21. I certify that (I) (this hospital) attended the deceased from <b>10/22/66</b> to <b>10/24/66</b> , that (I) (we) last saw the deceased alive on <b>10/24/66</b> , and that death occurred at <b>8:40 P.M.</b> from the causes and on the date stated above.					
22a. SIGNATURE <b>Lawrence Maryanov</b>			22b. DATE SIGNED <b>10/25/66</b>		
22c. PHYSICIAN'S NAME (Type) <b>Lawrence Maryanov</b>			22d. ADDRESS <b>610 Race St Cambridge, Md</b>		
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		23b. DATE THEREOF <b>Oct 28 1966</b>		23c. NAME OF CEMETERY OR CREMATORY <b>Prospect Hill Cemetery</b>	
23d. LOCATION (City, town or county) <b>York Penna</b>		23e. (State)			
24. FUNERAL DIRECTOR'S SIGNATURE <b>LeCompte Funeral Service, Cambridge, Maryland</b>			25a. REC'D BY REGISTRAR <b>OCT 27 1966</b>		
25b. REGISTRAR'S SIGNATURE <b>Charles Judge</b>					



# MARYLAND STATE DEPARTMENT OF HEALTH

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

## MEDICAL EXAMINER'S CERTIFICATE OF DEATH

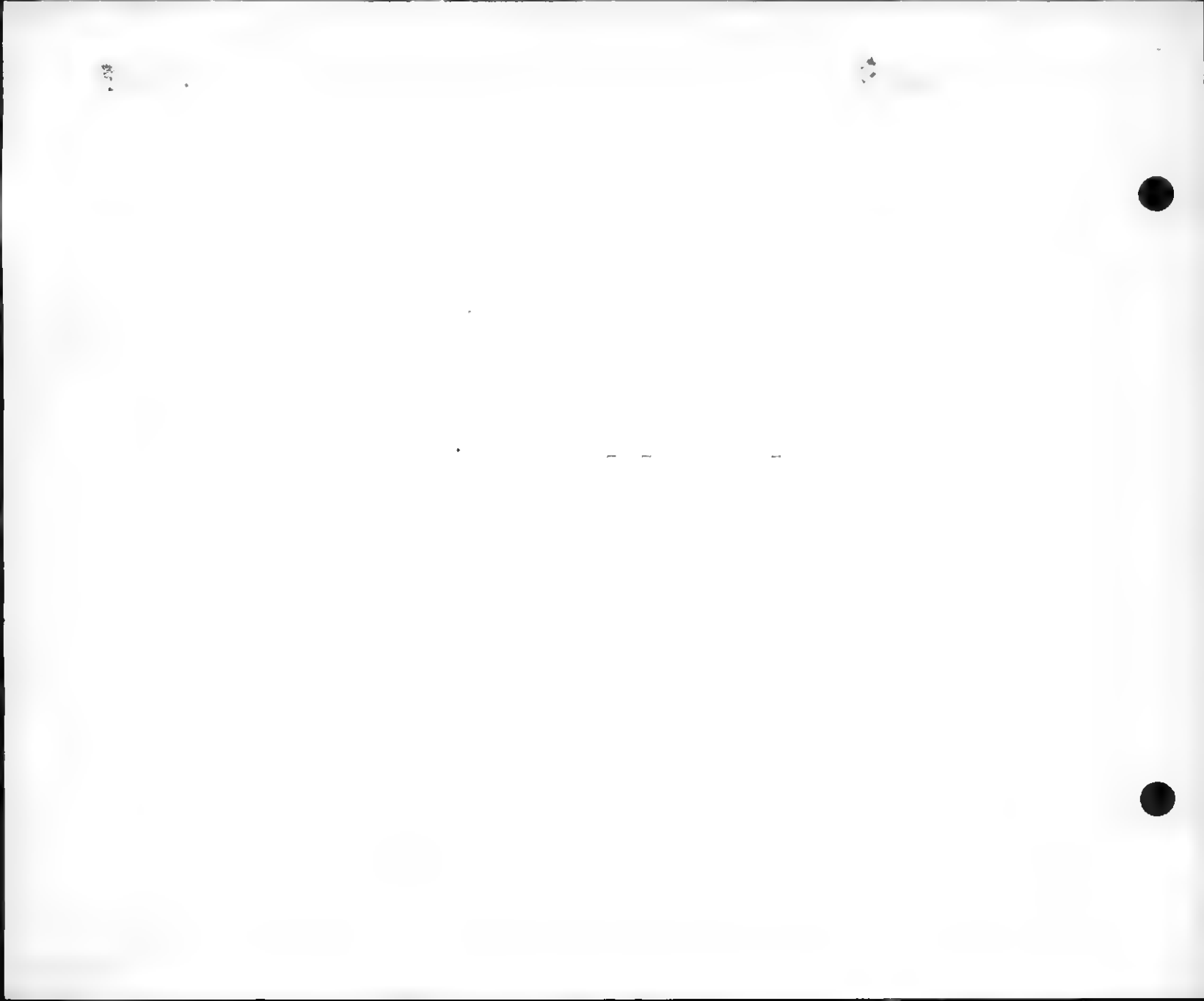
14121

FOR STATE  
HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health or its designated agent, prior to burial, cremation, or removal, and inform event within 72 hours after death.

1 PLACE OF DEATH a COUNTY <b>Dorchester</b> MARYLAND		2 USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a STATE <b>Maryland</b> b COUNTY <b>Dorchester</b>	
b CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Cambridge</b>		c LENGTH OF STAY N b <b>Life</b>	
d NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>Cambridge Maryland Hospital</b>		e STREET ADDRESS <b>403 Atlantic Avenue</b>	
3. NAME OF DECEASED (Type or print) <b>W. FRANK TURNER</b>		4 DATE OF DEATH Month <b>Oct.</b> Day <b>31</b> , Year <b>19 66</b>	
5 SEX <b>Male</b>	6 COLOR OR RACE <b>White</b>	7 MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8 DATE OF BIRTH <b>Mar. 8, 1904</b>
9 AGE (In years last birthday) yrs <b>62</b>		10 IF UNDER 1 YEAR Months <b>0</b> Days <b>0</b> Hours <b>0</b> Min <b>0</b>	
10a USUA. OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Highway Maintenance</b>		10b KIND OF BUSINESS OR INDUSTRY <b>Md. State</b>	
11 BIRTHPLACE (State or foreign country) <b>Cambridge, Maryland</b>		12 CITIZEN OF WHAT COUNTRY? <b>USA</b>	
13 FATHER'S NAME <b>Benjamin Turner</b>		14 MOTHER'S MAIDEN NAME <b>Mary Elzey</b>	
15 WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <b>NO</b>		16 SOCIAL SECURITY NO <b>220-12-1915</b>	
17 INFORMANT <b>Mrs. W. Frank Turner, Cambridge, Maryland</b>		Address	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <b>Pulmonary edema</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost (b) <b>Congestive Heart Failure</b> DUE TO (c) _____		INTERVAL BETWEEN ONSET AND DEATH <b>10 mins</b> <b>1 day</b>	
PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH		20b DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18)	
20c TIME OF INJURY Month, Day Year Hour <b>0</b> m. <b>19</b> p.m.		20d INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	
20e PLACE OF INJURY (Home, farm, factory, street, office bldg, etc)		20f (City or town) (County) (State)	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE <b>John Mace Jr. M.D.</b>		22. DATE SIGNED <b>11/1/66</b>	
EXAMINER'S NAME (Type) <b>John Mace Jr. M.D.</b>		CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MED. CA. EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/> Address (Street, city, town, or county) <b>Cambridge, Md.</b>	
23a BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>	23b DATE THEREOF <b>Nov 3 1966</b>	23c NAME OF CEMETERY OR CREMATORY <b>Dorchester Memorial Park</b>	23d LOCATION (City or Town) (County) (State) <b>Cambridge, Maryland</b>
24. FUNERAL DIRECTOR <b>LeCompte Funeral Service, Cambridge, Maryland</b>		25a REC'D BY REGISTRAR DATE <b>NOV 4 1966</b>	
25b REGISTRAR'S SIGNATURE <b>Charles Judge</b>			



# MARYLAND STATE DEPARTMENT OF HEALTH

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

## CERTIFICATE OF DEATH

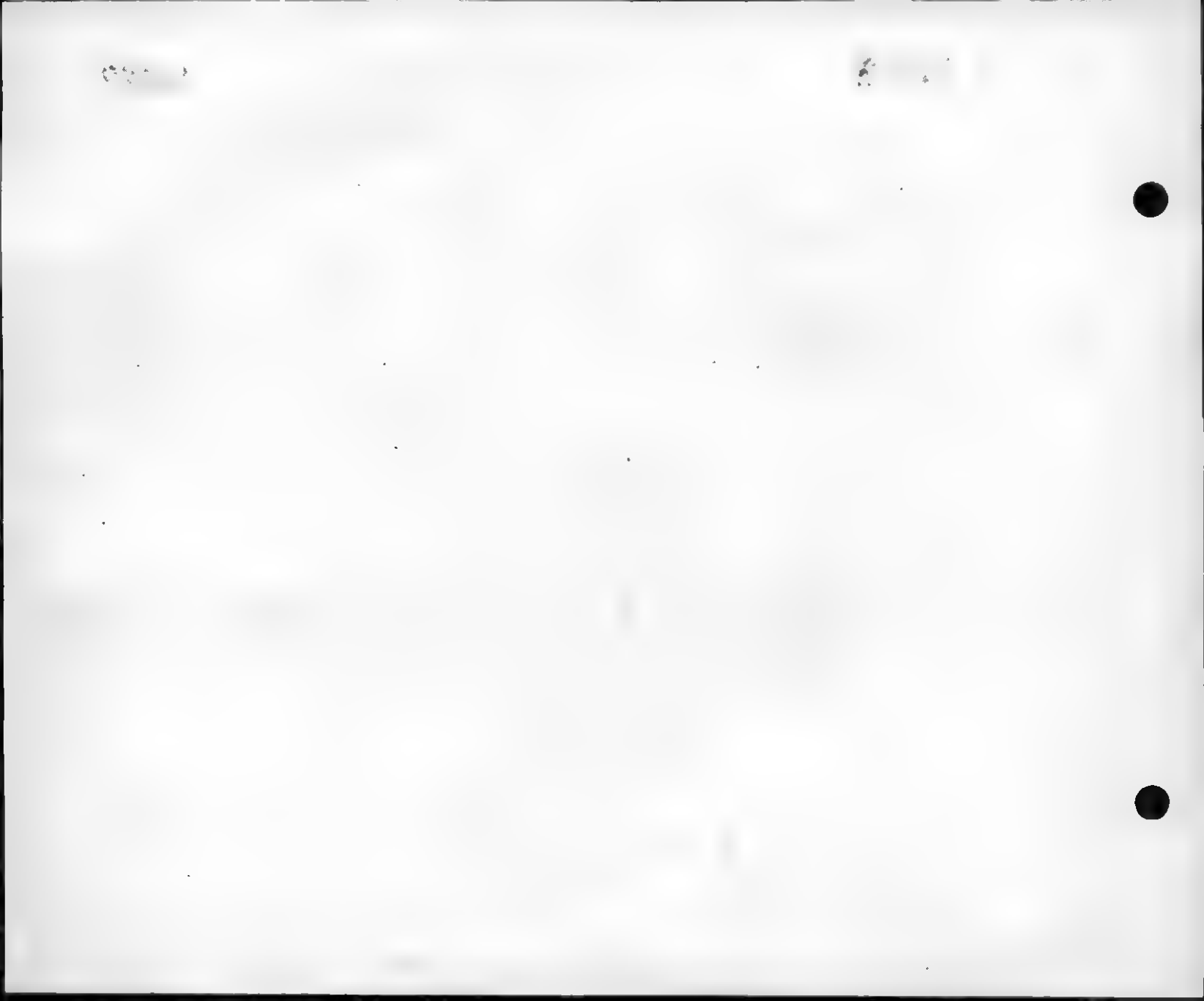
14122

14122

1. PLACE OF DEATH a. COUNTY <u>Dorchester</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived, if institution Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Queen Anne</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Cambridge RURAL</u>				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Chestertown RURAL</u>			
c. LENGTH OF STAY IN 1b <u>2 month 8 day</u>				d. STREET ADDRESS			
d. NAME OF HOSPITAL OR INSTITUTION (If not a hospital, give street address) <u>Eastern Shore State Hospital</u>				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>			
3. NAME OF <u>John W. Wark</u> (Type or print) First Middle Last				4. DATE OF DEATH <u>10 8 1966</u> Month Day Year			
5. SEX <u>M</u>		6. COLOR OR RACE <u>W</u>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>11/27/53</u> AGE (In years last birthday) <u>12</u>	
10a. USUA. OCCUPATION (Give kind of work done during most of work ng life, even if retired) <u>Ret. - Tool Maker</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>-</u>		11. BIRTHPLACE (County & State or foreign country) <u>Ireland PA.</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>John Wark</u>				14. MOTHER'S MAIDEN NAME <u>Mary Holmes UNKNOWN</u>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <u>NO</u>		16. SOCIAL SECURITY NO. <u>151-07-3956</u>		17. INFORMANT <u>Eastern Shore State Hospital Records</u> Address <u>Cambridge, Md.</u>			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Pneumonia</u> 470X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>-</u> DUE TO (c) <u>-</u>							INTERVAL BETWEEN ONSET AND DEATH <u>days</u>
PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Chronic Brain Syndrome</u>							19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18)					
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <u>19</u>		20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> of work		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from <u>08-01</u> , 19 <u>66</u> , to <u>10-8-66</u> , 19 <u>66</u> , that (I) <u>was</u> last saw the deceased alive on <u>10-8</u> 19 <u>66</u> , and that death occurred at <u>4:30</u> A.M. from causes and on the date stated above.							
22a. SIGNATURE <u>Felipe M. Dominguez</u>				ATTENDING PHYS. <input type="checkbox"/> MED. DIRECTOR <input checked="" type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22b. DATE SIGNED <u>10/9/66</u>	
22c. PHYSICIAN'S NAME (Type) <u>FELIPE M. DOMINGUEZ</u>				22d. ADDRESS <u>E. S. S. H.</u>			
23a. BURIAL, CREMATION, REMOVAL (Specify)		23b. DATE THEREOF		23c. NAME OF CEMETERY OR CREMATORY		23d. LOCATION (City or Town) (County) (State)	
<u>CREMATION</u>		<u>10/11/66</u>		<u>SILVERBROOK CREMATORY</u>		<u>WILMINGTON N.C. Co. DEL.</u>	
24. FUNERAL DIRECTOR		ADDRESS		25a. REC'D BY REGISTRAR		25b. REGISTRAR'S SIGNATURE	
<u>Edward Fellows</u>		<u>Wilmington, Md.</u>		DATE <u>OCT 13 1966</u>		<u>Charles Judge</u>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.



# MARYLAND STATE DEPARTMENT OF HEALTH

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

## CERTIFICATE OF DEATH

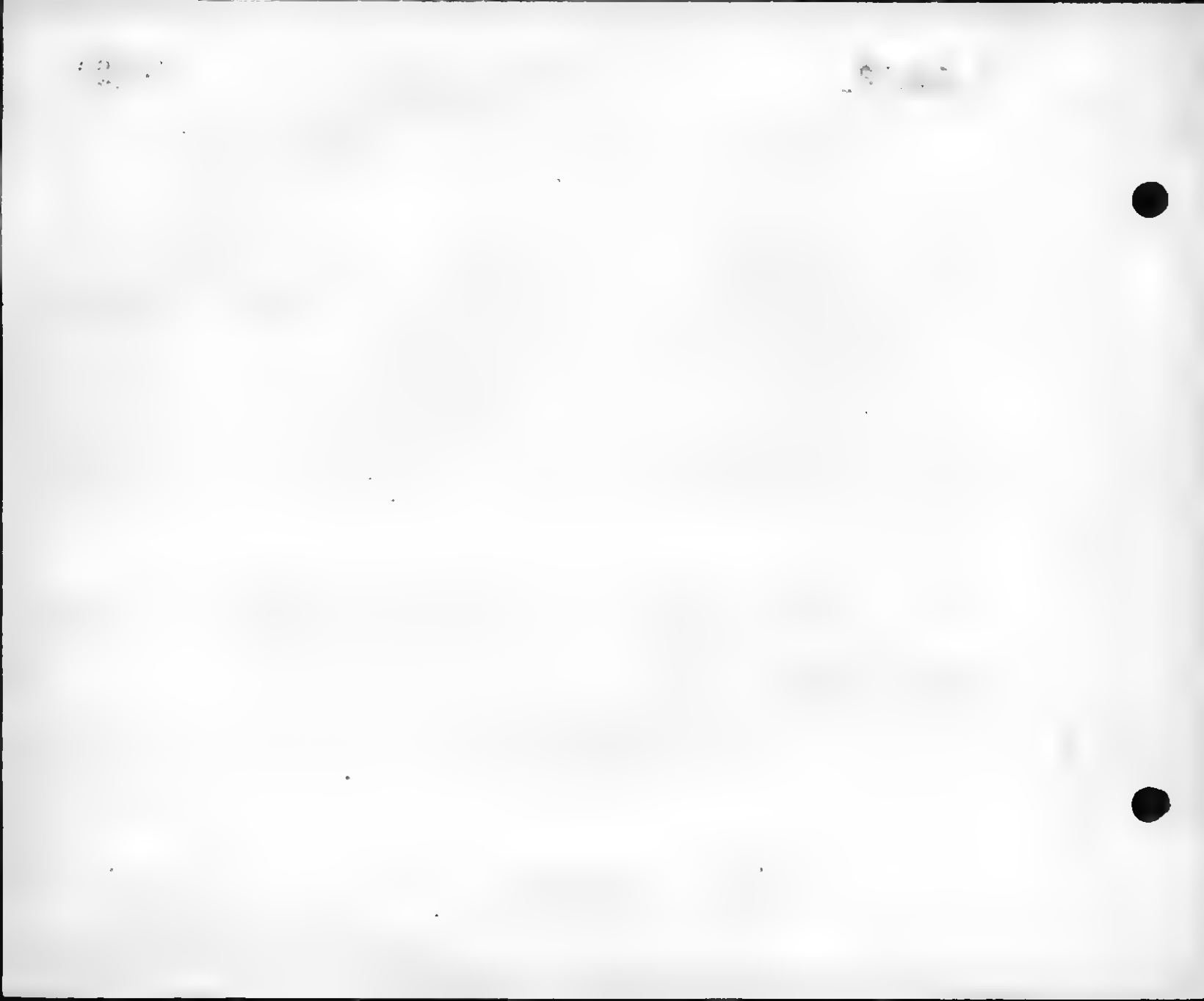
14123

14123

<b>1 PLACE OF DEATH</b> a. COUNTY <b>DORCHESTER</b> MARYLAND b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>RURAL CAMBRIDGE</b> c. LENGTH OF STAY in lb <b>2 1/2 YRS.</b> d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>EASTERN SHORE STATE HOSPITAL</b>		<b>2 USUAL RESIDENCE</b> (Where deceased lived, if institution Residence before admission) a. STATE <b>MARYLAND</b> b. COUNTY <b>KENT</b> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>RT. 2, CHESTERTOWN</b> d. STREET ADDRESS e. IS RESIDENCE ON A FARM? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
<b>3 NAME OF DECEASED</b> (Type or print) First <b>AMELIA</b> Middle <b>WATSON</b> Last <b>WATSON</b> <b>4 DATE OF DEATH</b> Month <b>OCTOBER</b> Day <b>14</b> Year <b>1966</b> <b>5 SEX</b> FEMALE <b>6 COLOR OR RACE</b> WHITE <b>7. MARRIED</b> <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> <b>8 DATE OF BIRTH</b> 10/7/82 <b>9. AGE</b> (In years last birthday) 84 yrs <b>10a. USUAL OCCUPATION</b> (Give kind of work done during most of working life, even if retired) <b>- Housewife</b> <b>10b. KIND OF BUSINESS OR INDUSTRY</b> <b>11. BIRTHPLACE</b> (County & State, or foreign country) <b>OHIO</b> <b>12. CITIZEN OF WHAT COUNTRY?</b> <b>U.S.</b>		<b>13 FATHER'S NAME</b> <b>JESSE D. BROWN</b> <b>14. MOTHER'S MAIDEN NAME</b> <b>MARY C. WALTER</b> <b>15. WAS DECEASED EVER IN U.S. ARMED FORCES?</b> (Yes, no, or unknown) (If yes give war or dates of service) <b>NO</b> <b>16. SOCIAL SECURITY NO.</b> 231 42 8401 <b>17. INFORMANT</b> Address <b>HOSPITAL RECORDS</b>	
<b>18. CAUSE OF DEATH</b> (Enter only one cause per line for (a), (b), and (c).) <b>PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a)</b> <b>myocardial infarction</b> <b>4201</b> DUE TO (b) <b>arterial hypertension</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (c) <b>general arteriosclerosis</b>		<b>PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)</b> <b>19. WAS AUTOPSY PERFORMED?</b> YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
<b>20a. ACCIDENT WAS UNDERLYING</b> <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) <b>20b. DESCRIBE HOW INJURY OCCURRED.</b> (Enter nature of injury in Part I or Part II of item 18.) <b>20c. TIME OF INJURY</b> Month, Day, Year Hour a.m. p.m. 19 <b>20d. INJURY OCCURRED</b> While at work <input type="checkbox"/> Not While at work <input type="checkbox"/> <b>20e. PLACE OF INJURY</b> (Home, farm, factory, street, office bldg., etc.) <b>20f. (City or town) (County) (State)</b>		<b>21. I certify that (I) (this hospital) attended the deceased from</b> 3/26, 1964, to 10/14, 1966, that (I) (we) last saw the deceased alive on 10/14 1966, and that death occurred at 9:25 M, from causes and on the date stated above. <b>22a. SIGNATURE</b> <i>Rene E. Smith</i> M.D. ATTENDING PHYS. <input type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/> <b>22b. DATE SIGNED</b> 10/14/66 <b>22c. PHYSICIAN'S NAME (Type)</b> RENE E. SMITH, M.D. <b>22d. ADDRESS</b> E.S.S. HOSPITAL, CAMBRIDGE, MD.	
<b>23a. BURIAL, CREMATION, REMOVAL (Specify)</b> <b>Burial</b> <b>23b. DATE THEREOF</b> Oct. 17, 1966 <b>23c. NAME OF CEMETERY OR CREMATORY</b> St. Paul Cem. <b>23d. LOCATION (City or Town) (County) (State)</b> nr. Chestertown, Md.		<b>24. FUNERAL DIRECTOR</b> ADDRESS <i>J. Willard Wells</i> Chestertown, Md. <b>25a. REC'D BY REGISTRAR</b> DATE OCT 18 1966 <b>25b. REGISTRAR'S SIGNATURE</b> <i>Charles Judge</i>	

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
 TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.



TO HOSPITAL OR ATTENDING PHYSICIAN: This law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

1

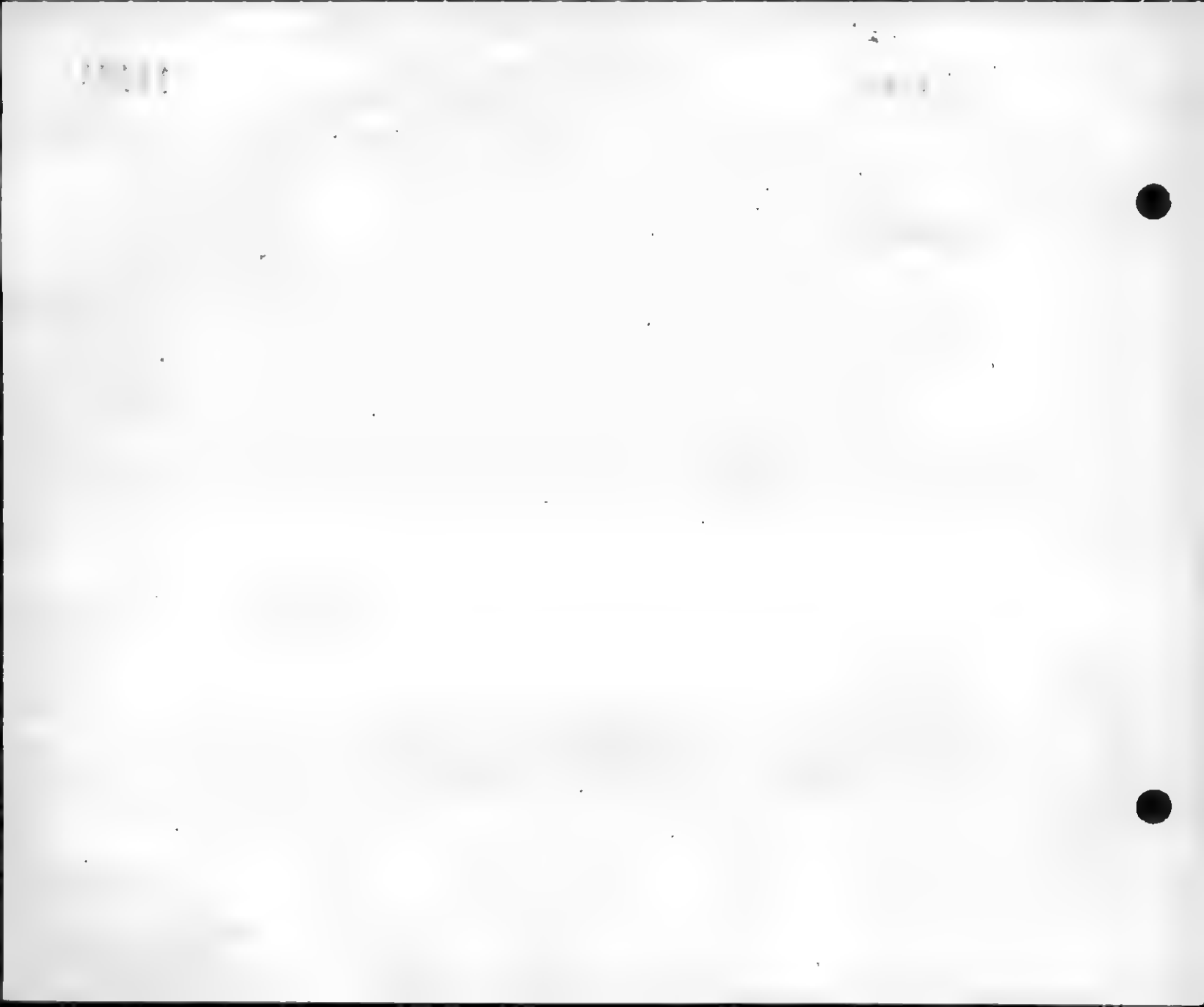
14124

MARYLAND STATE DEPARTMENT OF HEALTH  
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

CERTIFICATE OF DEATH

14124

1. PLACE OF DEATH a. COUNTY <u>Worcester</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution - Residence before admission) a. STATE <u>State</u> b. COUNTY <u>Worcester</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Rural - Cambridge</u>		c. LENGTH OF STAY IN 1b <u>3yrs. 10m. 6day</u>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Eastern Shore State Hospital</u>		d. STREET ADDRESS <u>209 Graham ave</u>	
3. NAME OF DECEASED (Type or print) First <u>Lucy</u> Middle <u>MARTIN</u> Last <u>Watson</u>		4. DATE OF DEATH Month <u>Oct.</u> Day <u>15</u> Year <u>1966</u>	
5. SEX <u>Female</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>03-10-73</u>
9. AGE (In years last birthday) <u>93</u> yrs		IF UNDER 1 YEAR Months Days Hours Mins. IF UNDER 24 HRS.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>UNKNOWN</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>md.</u>	
11. BIRTHPLACE (County & State, or foreign country) <u>md.</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>Unknown William Larr</u>		14. MOTHER'S MAIDEN NAME <u>Unknown Harriett Sturgis</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <u>unknown</u>		16. SOCIAL SECURITY NO. <u>UNKNOWN</u>	
17. INFORMANT <u>Med. Records</u> Address <u>Eastern Shore State Hospital</u>			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Generalized Advanced Arteriosclerosis</u> 4201 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>with Aortic Stenosis</u> DUE TO (c) <u>and probable myocardial infarction</u>		INTERVAL BETWEEN ONSET AND DEATH	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <u>19</u>		20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that <u>we</u> (this hospital) attended the deceased from <u>Jan. 9</u> , 19 <u>63</u> to <u>Oct. 15</u> , 19 <u>66</u> , that <u>we</u> last saw the deceased alive on <u>October 15, 1966</u> , and that death occurred at <u>7:25</u> P.M. from causes and on the date stated above.			
22a. SIGNATURE <u>Edward Lewis Jr. M.D.</u>		22b. DATE SIGNED <u>10/15/66</u>	
22c. PHYSICIAN'S NAME (Type) <u>EDWARD LEWIS JR. - MD</u>		22d. ADDRESS <u>5800 BEECH AVENUE BETHESDA, MARYLAND</u>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		23b. DATE THEREOF <u>10/18/66</u>	
23c. NAME OF CEMETERY OR CREMATORY <u>SPRING HILL CEM</u>		23d. LOCATION (City or Town) (County) (State) <u>GARDEN STREE MD</u>	
24. FUNERAL DIRECTOR <u>Annie A. Burbage</u> ADDRESS <u>Berlin Md</u>		25a. REC'D BY REGISTRAR <u>Charles Judge</u> DATE <u>OCT 18 1966</u>	
		25b. REGISTRAR'S SIGNATURE	



# MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

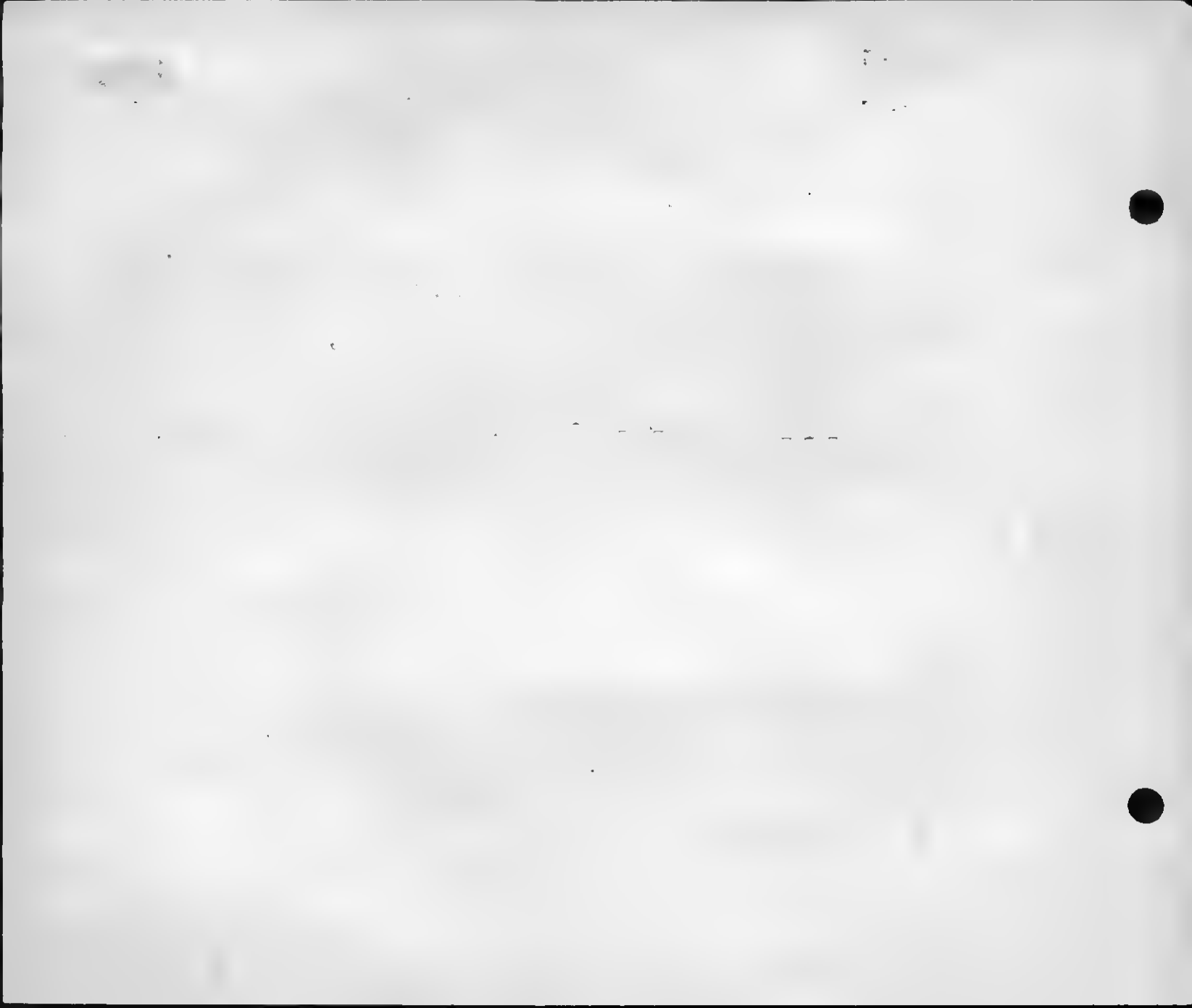
## CERTIFICATE OF DEATH

14125

14125

<b>1. PLACE OF DEATH</b> a. COUNTY <u>Dorchester</u> <span style="float: right;">MARYLAND</span>				<b>2. USUAL RESIDENCE</b> (Where deceased lived, if institution; residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Dorchester</u>			
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>Cambridge</u>				c. LENGTH OF STAY IN 1b <u>8 days</u>			
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <u>Cambridge Maryland Hospital</u>				e. STREET ADDRESS <u>None</u>			
<b>3. NAME OF DECEASED</b> (Type or print) First Middle Last <u>HUBERT</u> <u>EDGAR</u> <u>WILLEY</u>				<b>4. DATE OF DEATH</b> Month Day Year <u>Oct. 25, 1966</u>			
5. SEX <u>Male</u>		6. COLOR OR RACE <u>White</u>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>June 19, 1906</u>	
9. AGE (In years last birthday) <u>60</u> yrs.		IF UNDER 1 YEAR Months Days		IF UNDER 24 HRS. Hours Min.		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>waterman</u>				10b. KIND OF BUSINESS OR INDUSTRY <u>Seafood</u>		11. BIRTHPLACE (County & State, or foreign country) <u>Dorchester Co., Maryland</u>	
12. CITIZEN OF WHAT COUNTRY? <u>USA</u>				13. FATHER'S NAME <u>John Elzey Willey</u>			
14. MOTHER'S MAIDEN NAME <u>Minnie Shorter</u>				15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give year or dates of service) <u>No</u>			
16. SOCIAL SECURITY NO. <u>214-07-9343</u>				17. INFORMANT <u>Mrs. Hubert E. Willey, Fishing Creek, Md.</u>			
<b>18. CAUSE OF DEATH</b> (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Metastasis to Brain</u> DUE TO (b) <u>Oat Cell Carcinoma</u> Conditions, if any, which gave rise to immediate cause (c), stating the underlying cause last.							INTERVAL BETWEEN ONSET AND DEATH <u>4 mos</u> <u>2 mos</u>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from <u>Jan 19, 1965</u> to <u>10-25, 1966</u> that (I) (we) last saw the deceased alive on <u>10-25, 1966</u> , and that death occurred at <u>4:25 PM</u> , from the causes and on the date stated above.							
22a. SIGNATURE <u>W. N. Baumann</u> M.D.				ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22b. DATE SIGNED <u>10-26-66</u>	
22c. PHYSICIAN'S NAME (Type) <u>W. N. Baumann, MD</u>				22d. ADDRESS <u>Cambridge, Maryland</u>			
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		23b. DATE THEREOF <u>Oct 27 1966</u>		23c. NAME OF CEMETERY OR CREMATORY <u>Dorchester Memorial Park</u>		23d. LOCATION (City, town or county) (State) <u>Cambridge, Maryland</u>	
24. FUNERAL DIRECTOR'S SIGNATURE <u>LeCompte Funeral Service, Cambridge, Maryland</u>				ADDRESS <u>LeCompte Funeral Service, Cambridge, Maryland</u>		25a. REC'D BY REGISTRAR DATE <u>OCT 31 1966</u>	
25b. REGISTRAR'S SIGNATURE <u>Charles Judge</u>							

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
 TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.



**FOR STATE  
HEALTH DEPT.**

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-2. Page 5 may be retained for your files.  
TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health at its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

VR A15ME (5)  
6M 1/66

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

**MEDICAL EXAMINER'S CERTIFICATE OF DEATH**

14126

14126

1. PLACE OF DEATH a. COUNTY <b>Dorchester</b> MARYLAND				2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Dorchester</b>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Cambridge</b>			c. LENGTH OF STAY in 1b <b>12 years</b>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Cambridge</b>		
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b># 1, Travers Court Apt's</b>				d. STREET ADDRESS <b># 1, Travers Court Apt</b>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <b>JOHN</b> First <b>FONTAINE</b> Middle <b>WILLIS, Jr</b> Last				4. DATE OF DEATH Month <b>Oct.</b> Day <b>18</b> Year <b>66</b>			
5. SEX <b>Male</b>		6. COLOR OR RACE <b>White</b>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <b>Aug. 22, 1886</b>	
9. AGE (In years last birthday) yrs. <b>80</b>		10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Salesman</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Shoe</b>		11. BIRTHPLACE (State or foreign country) <b>Dorchester Co., Maryland</b>	
12. CITIZEN OF WHAT COUNTRY? <b>USA</b>		13. FATHER'S NAME <b>John F. Willis</b>				14. MOTHER'S MAIDEN NAME <b>Lottie J. Bennett</b>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <b>Yes WW I</b>		16. SOCIAL SECURITY NO. <b>Unknown</b>		17. INFORMANT Address <b>Mr. Gordon Willis, Washington, D. C.</b>			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>4201 Coronary occlusion</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							INTERVAL BETWEEN ONSET AND DEATH <b>Instant</b>
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING CAUSE OF DEATH <input type="checkbox"/>				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <b>19</b>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>							
ACTUAL SIGNATURE <i>John Mace Jr.</i> M.D. EXAMINER'S NAME (Type) <b>John Mace Jr. M.D.</b>				22. DATE SIGNED <b>10/24/66</b> Address (Street, city, town, or county) <b>Cambridge, Md.</b>			
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		23b. DATE THEREOF <b>Oct. 20 1966</b>		23c. NAME OF CEMETERY OR CREMATORY <b>Cambridge Cemetery</b>		23d. LOCATION (City or Town) (County) (State) <b>Cambridge, Maryland</b>	
24. FUNERAL DIRECTOR ADDRESS <b>LeCompte Funeral Service, Cambridge, Maryland</b>				25a. REC'D BY REGISTRAR DATE <b>OCT 26 1966</b>		25b. REGISTRAR'S SIGNATURE <i>Charles Judge</i>	

MEDICAL CERTIFICATION

ASTI

ASTI

1

MARYLAND STATE DEPARTMENT OF HEALTH

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

CERTIFICATE OF DEATH

14127

14127

1. PLACE OF DEATH a. COUNTY <b>DORCHESTER</b> MARYLAND				2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <b>MARYLAND</b> b. COUNTY <b>DORCHESTER</b>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>CAMBRIDGE (RURAL)</b>				c. LENGTH OF STAY IN 1b <b>3 YEARS</b>			
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>EASTERN SHORE STATE HOSPITAL</b>				e. STREET ADDRESS <b>RED # 1</b>			
3. NAME OF DECEASED (Type or print) First <b>WALTER</b> Middle <b>YOUNG</b> Last <b>YOUNG</b>				4. DATE OF DEATH Month <b>OCTOBER</b> Day <b>31</b> Year <b>1966</b>			
5. SEX <b>MALE</b>		6. COLOR OR RACE <b>NEGRO</b>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <b>12-17-05 1890</b>	
9. AGE (In years last birthday) <b>81 75 yrs.</b>		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>RETIRED Farmer</b>		11. BIRTHPLACE (County & State, or foreign country) <b>Dorchester County MARYLAND</b>		12. CITIZEN OF WHAT COUNTRY? <b>USA</b>	
13. FATHER'S NAME <b>STEVEN YOUNG</b>				14. MOTHER'S MAIDEN NAME <b>EMILY (maiden name unknown)</b>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <b>Yes WW I</b>		16. SOCIAL SECURITY NO. <b>215-16-3617</b>		17. INFORMANT <b>RECORDS OF THE EASTERN SHORE STATE HOSPITAL</b>			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Heart failure</b> 4211 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <b>Arteriosclerosis</b> DUE TO (c) <b>Arteriosclerosis</b>							INTERVAL BETWEEN ONSET AND DEATH
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)							19. WAS AUTOPSY PERFORMED? <b>YES</b> <input checked="" type="checkbox"/> <b>NO</b> <input type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <b>19</b>		20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work at work		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from _____, 19____, to _____, 19____, that (I) (we) last saw the deceased alive on _____, 19____, and that death occurred at _____ M, from causes and on the date stated above.							
22a. SIGNATURE <b>W. Rieckert</b>				22b. DATE SIGNED <b>10-31-61</b>		22c. PHYSICIAN'S NAME (Type) <b>Peter W. Rieckert</b>	
22d. ADDRESS <b>E-New Market, Md</b>				22e. MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>			
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		23b. DATE THEREOF <b>Nov. 3, 1966</b>		23c. NAME OF CEMETERY OR CREMATORY <b>Salem Cemetery</b>		23d. LOCATION (City or Town) (County) (State) <b>Near Vienna, Maryland</b>	
24. FUNERAL DIRECTOR <b>Tramptom Funeral Home Federalburg Md</b>				25a. REC'D BY REGISTRAR <b>DATE NOV 3 1966</b>		25b. REGISTRAR'S SIGNATURE <b>Charles Judge</b>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

TS141

1940 10 12 00 00

TS141

10-12-40 10 12 00 00 10-12-40 10 12 00 00

10-12-40 10 12 00 00

10-12-40 10 12 00 00

10-12-40 10 12 00 00

10-12-40 10 12 00 00

10-12-40 10 12 00 00

10-12-40 10 12 00 00

10-12-40 10 12 00 00

10-12-40 10 12 00 00

10-12-40 10 12 00 00

10-12-40 10 12 00 00

10-12-40 10 12 00 00

10-12-40 10 12 00 00

10-12-40 10 12 00 00

10-12-40 10 12 00 00

10-12-40 10 12 00 00

10-12-40 10 12 00 00

10-12-40 10 12 00 00



10-12-40 10 12 00 00

10-12-40 10 12 00 00